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ABSTRACT

The National Institute of Child Health and Human Development (NICHD) Study of Early Child Care is an ongoing, prospective, 3-year longitudinal study of over 1,300 full-term healthy infants and families from 10 sites across the United States. While the sample is not nationally representative, the subjects come from major regions of the country: the East Coast, the West Coast, the Mid-West, the North, and the South. They come from urban and from rural settings, and include minorities as well as single-parent and two-parent families. The study examines the concurrent, long-term, and cumulative influences of variations in early child care experiences on the cognitive, linguistic, social, emotional, and physical development of infants and toddlers. The study design takes into account the complex interactions among characteristics of the family and home, of the child care environments, and of the child. Subject recruitment started in January 1991, and data collection was scheduled to end at the beginning of 1995. Data collection involved periodic telephone calls to families beginning at 3 months and home visits, child care center visits, or laboratory assessments at 1, 6, 15, 24, and 36 months. This document is volume 5 of a 5-volume operations manual that explains, in 29 chapters, the procedures used in conducting the NICHD study. Volume 5 consists of chapters 25 through 29. Chapter 25 provides instructions for conducting follow-up telephone interviews at 35 months. Subsequent chapters address the 36-month visits and laboratory assessments. Chapter 26 presents an overview of the visits to the child's home and child care center, and laboratory assessments. Chapter 27 provides instructions for conducting the visit to the child care center. Instructions for conducting the 36-month home visit are given in chapter 28, which also includes specific instructions for administering the Bracken Basic Concept Scale and a home inventory, information about conducting standardized interviews and questionnaires, and instructions for gathering data on ear infections. Chapter 29 provides instructions for: (1) conducting the 36-month laboratory assessment; (2) observing children's solitary play and clean-up activities; (3) conducting a modified Strange Situation procedure; (4) administering and coding the Reynell Developmental Language Scales; (5) measuring children's self-control; (6) assessing the quality of mother-child interaction; (7) administering the Peabody Picture Vocabulary Test; (8) assessing children's television viewing habits; (9) assessing children's behavioral and emotional problems; and (10) measuring children's physical growth. (BC)

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NICHD Study of Early Child Care

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VOLUME V

35 Month Manual
36 Month Manuals

PS 024319

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ADDENDUM TO CHAPTER 25
INFORMATION REGARDING THE 35 MONTH PHONE CALL

I. Mothers Who Aren't Using Child Care For the Summer

There are several mothers who are not using child care for the summer, but plan to resume child care in the fall. A decision was necessary regarding call backs to the mothers to schedule child care visits and to collect final 35 month data. The following plan is consistent with previous data collection periods:

1. The 35 month phone call "call back" should be made within the regular 36 month window. No calls will be made during the exception period.

2. Observations of resumed or started care (information gathered from the "call-back") will be scheduled to occur during the exception period. According to the study decision, sites will only observe care arrangements that have been in place for at least two weeks.

II. Moms Who are Child Care Providers and Have A Regular "Other" Arrangement

For moms who are child care providers and have a regular "other" arrangement, ignore the skip pattern after question #14. This is so that information for questions #14 through #37 are completed and thus both types of arrangements will then have data.

III. Stopped Arrangements

Some sites have wondered how long a period of time is needed for an interruption in a child care situation to consider it stopped care? For instance, there was a situation in which the family moved and the live-in caregiver was not caring for the child for a 2-3 week period of time while the family moved. In this case and all other cases, use two weeks as the rule.

IV. Co-operative and Regular Pre-school Arrangements

Sites have been worried that they have missed some child care arrangements if mothers do not consider co-operatives or preschools as an "arrangement". (This issue is also an issue for the 3-month calls.) Please note that co-operative preschools and regular preschools may be considered as types of child care arrangements that the mother may have started or stopped. If a child attends a co-operative preschool or a regular preschool it should be coded as center care, and if the mom volunteers/works there, then the child is considered to be in care with the mom.

As for number of adults supervising the children, code the number of adults present at any one time (vs. total number of adults that the child comes in contact with).

If you are one of the sites that has mother co-op centers, please schedule your child care visits on days when the mother is not present or not in charge of her own child, if at all possible.

V. Coding Unique Child Care Arrangements

1. A Montessori School in the teacher's home - the teacher has indicated that she is a licensed as a center. The school is in the basement of her home and the children do not use the residential part of the home.

This situation should be coded as CENTER CARE. The deciding factor is that the arrangement is officially licensed as a center. If there was no center license, it would be a family home care arrangement.

2. Music lessons, swimming lessons, gymnastics, etc ARE NOT considered child care arrangements.

3. Joint custody - for Phase I, the time the study child spends with the father in joint (shared) custody is not considered child care. If the father cares for the child beyond his normal custody arrangement, those hours can be considered child care.

4. Child care arrangements used by the father when child is in his custody - for Phase I, use only the information about child care arrangements as given by the mother. We have not asked fathers about child care arrangements. Therefore, if the mother doesn't know what arrangements the father uses, you would NOT CALL the father for the information. This may change for Phase II.

5. Mom enrolled in a residential treatment program - the mom and child are in the residential treatment program 24 hours a day. However, the child is in a nursery part of the time without his mother, with his mother in the nursery another part of the time, and the child also stays with his grandmother in her home overnight a day and a half each week.

This situation has 3 separate child care arrangements. The nursery in the treatment program should be observed when the mother is not caring for the child, as this is the most formal of the arrangements.

6. Father has legal custody of the study child - the father was interviewed and the child care arrangement he used was observed at 15 & 24 months. At 36 months, the mother had visitation rights but the child is in the care of the father the majority of the time.

The 36 month visits and interviews should CONTINUE WITH THE FATHER. The child care arrangement used by the father should continue to be observed at 36 months.

This may be modified for the Phase II study, but for Phase I we will be consistent with the decision rules used up to this point.

7. If there is a situation in which the study child is in care more than ten hours a day on a regular weekly basis, and the child is awake for at least 3 hours of that time, then the fact that it takes place all on the same day does not matter. It is an observable care arrangement. At three years of age, that child knows that on that particular weekday each week, s/he will be in non-maternal care for all day.

However, nine hours of child care in 1 day does not qualify as observable child care. The 10 hour criterion is still used at 36 months.

CHAPTER 25

ADMINISTRATION MANUAL FOR THE 35-MONTH PHONE INTERVIEW

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CHAPTER 25

ADMINISTRATION MANUAL FOR THE 35-MONTH PHONE INTERVIEW

I. PURPOSE OF THE MANUAL

This manual provides specific information about the questions included in the 35-month phone interview. In addition, this manual serves as the archival description of the way in which these phone interview data were collected. Many of these procedures are identical to those implemented for the follow-up phone contacts (the 3-, 9-, 12-, etc. month calls). It is modelled on the 5- 13- and 23-month calls developed by Deborah Phillips. Marion O'Brien and Katy Zima from the Kansas Site made extensive contributions to incorporate the Peer Play Observation procedures into this manual.

This manual will be modified if necessary during training and data collection. Any suggestions for additions or amendments should be addressed to Deborah Phillips at the Virginia Site and to the Data Coordinating Unit.

If you have a question about any aspect of these calls, send a computerized mail message to Deborah Phillips and the Data Center. The questions and their responses will be sent to ALL sites.

As a prelude to studying this manual, we recommend that each caller review the information about standardized interviewing techniques contained in the home visit manuals.

II. OVERVIEW OF THE INTERVIEW

The 35-month telephone contact serves several purposes. First, it is used to obtain current child care information. In these cases, "current" means that the data for these calls need to reflect the target child's child care arrangements (or lack thereof) at 36 months. THESE CALLS ARE INTENDED TO REFLECT THE CHILD CARE ARRANGEMENT THAT IS OBSERVED, IN CASES WHERE THERE IS OBSERVABLE CARE. IF YOU HAVE MADE A PRIOR CALL THAT DOES NOT CAPTURE THE OBSERVABLE ARRANGEMENT (I.E. AT THE HOME VISIT YOU LEARN THAT THE FAMILY HAS SWITCHED FROM THE GRANDMOTHER TO A FAMILY CARE DAY CARE HOME), THEN YOU MUST REPEAT THIS CALL, FROM START TO FINISH.

Second, it is used to determine whether, for children in child care, any of their current arrangements fit the criteria for "primary child care arrangements" that we will observe at 36-months.

Third, it is used to obtain information on changes in child care arrangements since the 33-month follow-up phone call.

Fourth, it MAY be used to determine the availability of an appropriate peer for observation at 36 months. Although this manual assumes that the 35-month caller will conduct this task, sites may adjust this procedure to meet their needs. IT IS ESSENTIAL THAT YOU BE VERY FAMILIAR WITH THE PEER OBSERVATION MANUAL BEFORE INITIATING THE 35-MONTH CALLS.

Fifth, it MAY be used to schedule the 36-month home and lab visits. Although the manual makes the assumption that the 35 month caller will schedule the home, lab, and child care visits, sites are permitted to adjust this procedure to meet their needs. For example, sites may choose to let their home visitors (RAs) schedule these visits in a separate call. Just be sure not to overburden the families with too many extra phone calls and to keep the data collection within the windows. It is important, however, that these schedulers use the language from the scripts in the 35-month (see pgs 74 - 76 in this manual) call when describing the relevant assessments.

There are several possible outcomes of this interview:

1. CHILD is not currently in any form of child care ("no" to Question 14); the mother is currently not working or going to school ("no" to Question 16); and she does not expect to be using regular care, working, or going to school at the time of the child care assessment ("no" to Questions 15 and 17), or to change arrangements before the next child care assessment ("no" to Question 45).

In this case, you will schedule the 36-month home and lab visits and there will be no regular child care visit at 36-months. You will, however need to determine if the child plays regularly with a peer in another setting (see Part 5D). If so, then you will give the mother information about the peer play observation and begin the arrangements for that observation.

2. CHILD is in some regular child care ("yes" to Question 14, or "yes" to Question 16 and you learn that mother takes care

of CHILD at home, or takes the child to work, or does actually have some other form of regular care), but it does not fit our criteria as a Primary Child Care Arrangement for a 36-month child care visit. If the mother does not expect to change child care by the time of the next child care assessment ("no" to Question 45), you will schedule the 36-month home and lab visits, and determine whether the study child can be observed with a peer in another setting (see Part 5D). There will be no child care visit at 36-months.

If the mother does expect to change child care within the window for the 36-month child care visit (up to 38 months 0 days) see 4, below.

3. CHILD is in some regular child care ("yes" to Question 14, or "yes" to Question 16 and you learn that mother takes care of CHILD at home, or takes the child to work, or does actually have some other form of regular care), and it does fit our criteria as a Primary Child Care Arrangement for a 36-month child care visit.

In this case, you will need to follow the script in Part 5 to determine the primary child care arrangement and set in motion the process of contacting the caregiver about the visit. This can go one of two ways:

(a) Either the mother gives you permission to contact the provider directly, or

(b) She wants to contact the provider first, in which case you will need to recontact the mother to find out about the outcome of her contact prior to making a direct caregiver contact.

You will schedule the 36-month home and lab visits.

You will also determine whether the study child can be observed with a peer in the child care setting (see Part 5D) or in another setting.

4. CHILD is not currently in any form of child care ("no" to Question 14); the mother is currently not working or going to school ("no" to Question 16); BUT the mother does expect to be using regular care, working, or going to school by the time of the next child care assessment ("yes" to Questions 15 and 17), OR she expects to change her child care arrangements by the next child care assessment ("yes" to Question 45). The "next" child care assessment means within the window for the 36-month child care assessment (up to 38 months, 0 days).

In these cases, you will obtain the information about what the mother plans to be using for child care (see Question 46) and should have this information handy when you make the call-back. You then need to schedule a call-back to the mother at the time that her new arrangement is in place and redo the entire interview. This repeat interview will then serve as the data from which to determine whether to conduct a 36-month child care visit. DO NOT SEND THE MARK-SENSE FORMS FROM THE FIRST 35-MONTH CALL TO THE DATA CENTER. Send ONLY the second interview to the Data Center.

However, we recommend that you schedule the 36-month home and lab visits after the first interview.

With respect to the peer observation, we recommend that you inquire about the availability of a peer that meets the peer observation criteria at the time of the first interview and, if applicable, conduct the peer observation independently of the child care observation. If the study child does not play regularly with a peer, you will need to inquire about peers in the new/changed child care setting when you conduct the follow-up 35-month call (see Part 5D). For additional suggestions see the problem solving section of the peer manual.

PLEASE NOTE: Your ultimate goal is to assure that observable child-care arrangements are assessed prior to the end of the allowable windows (38 months, 0 days with exception period extending to but not including 41 months, 0 days). Section III.A. describes the minimum number of required calls, and procedures for repeat attempts to reach the families. You will need to adapt these procedures for individual families. For example, some families may tell you that they are starting a new arrangement at 35 months, 2 weeks, but you learn that the switch has been delayed another week. In this case, you will need to make a second, call-back appointment.

Sometimes a family will start to change child care WITHIN the windows for data collection. If you are aware of this change/start-up in advance you may have a choice about which child care to observe. Please use the following guidelines in this situation.

(a) Observe the "old" arrangement if observing the new arrangement pushes you close to the end of the window. This will often be the case given the two week waiting period before an observation can be made.

(b) Observe the "old" arrangement if it lasted for three or more months.

(c) Observe the "new" arrangement if the "old" arrangement consists of father care, but ONLY if you are confident that you can schedule the child care visits within the window.

For example, if you know that a family is switching child care at 37 months, you will need to decide whether to observe the old arrangement at 36 months (highly preferable: first visit at 36 mo, 0 weeks and second visit at 36 mo, 2 weeks) or whether to see the child in his/her new arrangement after the required two weeks of adaptation (first visit at 37 mo, 2 weeks, second visit prior to 38 mo, 0 days).

Sometimes you will make the call-back and discover that the family has NOT changed child care. In this case (assuming that the "old" arrangement is not going to change in the next couple of weeks), check with the mother to see if the information from the original call is still accurate (e.g., hours of care each day, address of arrangement) and schedule the child-care visit. Send the original call to the data center if nothing has changed.

We suggest that you retain the 35-month call forms until the child care visit is completed for any given target child. This will avoid situations in which initial call data are sent, and then you discover a subsequent change in arrangements that necessitates a call back, and a second set of data being sent to the Data Center.

If you want consultation on these "in-between" and unusual cases, call Deborah Phillips at the Virginia site, and she will contact the Data Coordinating Center and all sites if important clarifications are involved. For suggestions on how to proceed with the selection of a peer for observation see the problem solving section of the peer manual.

III. INSTRUCTIONS FOR CALLING

The 35-month call may be started at 34 months 14 days (2 weeks prior to the child's 35 month birthday). There are no close dates for these windows and there are no exception periods for these calls. Again, use these calls to schedule the 36-month lab, home, peer and child care visits within their windows.

It is important for sites to make conscientious attempts to reach the mothers. By this visit, we have significant resources invested in these families; failure to contact the families results in a smaller sample. If the family has a phone but the mother has not been contacted in the first 3 days of regular attempts, efforts should be increased to include evening and weekend calls. A minimum of seven calls should be placed during the first week's attempts - three evening, two morning and two afternoon calls. If the mother is not contacted by the end of the first week of attempts, initiate the procedures outlined under What to do if you cannot reach the family by phone. If the mother is not reached by any of these means at 35-months, the same set of seven calls for contacting the mother should be repeated at 36-months, if needed. Again, these particular dates are not etched in stone. Your goal is to assure that we obtain the necessary information for the child care, home, and lab visits at 36-months, within the allowable windows.

The child's mother must be contacted and interviewed in all cases. The only exception to this rule is situations where the mother is out of phone range for some unusual reason (serving in the military, for example) and will not return until after the data collection window is closed. In this case, conduct the interview with the child's father if possible, or, if there is no father involved, with the child's primary caregiver. Indicate on the interview face sheet the relationship of the person who has been interviewed (0 = mother, 1 = father, 2 = grandmother, 3 = other relative, 4 = primary caregiver. If the mother is out of town but able to be called, she should be contacted wherever she is. Similarly, if the mother is out of contact for a short period of time (as in the hospital), arrange to call her back when she has returned home if this will be within the window for data collection.

If the mother is no longer living in the same household with the child, determine who the child's primary caregiver is. Use the Alternate Caregiver forms and manual to collect the data. This caregiver of the child should then be contacted and informed about the study. If he or she is interested in participating, use local guidelines to obtain informed consent. Code relationship as above, for example, if the mother has moved out, leaving her child with the grandmother, code 2 for grandmother as primary caregiver, not 0 for mother.

With respect to the 36 month lab and home visits, if you find during this call that the primary caregiver has changed, you must determine who is the current caregiver and what their past relationship has been with the child. You will conduct the lab and home visits with the current caregiver.

Please make a special note of any cases where the primary caregiver is no longer the mother. COMMUNICATE THIS INFORMATION TO THE 36-MONTH LAB AND HOME TEAMS AND SCHEDULERS.

A. When to make the calls

The window for making the 35-month calls to the family begins when the child is 34.5 months. You do not need to start making the calls at 34.5 months. Again, use your best judgment about what is going to enable you to schedule all of the 36-month visits within the windows. If the mother is not reached, a minimum of seven calls should be attempted (consisting of at least three calls during the evening, two calls during the morning, and two calls during the afternoon). If the phone has been disconnected, the number is changed to an unlisted one, the family does not have a phone, or if there is no answer, follow the procedures outlined in Subsection E, "What to do if you cannot reach the family by phone."

If all of the procedures fail, wait until the child's 36-month birthday and repeat the call sequence of a minimum of seven calls. Repeat at the 37-month and 38-month birthdays if necessary.

B. What to do if you cannot complete the interview in a single call

Families with young children have to cope with a lot of interruptions. If the interview cannot be completed at one time, arrange a specific time to call back before the end of the following day. Thus, the second call should be within 36 hours of the first call. If this is possible, the second interview can proceed from the point where the first interview left off. If more than 36 hours elapse between calls, start the interview over at the beginning. Say something like, *"I'm going to start at the beginning to be sure we haven't forgotten anything,"* and use confirmatory language (e.g., *"You are using regular child care?"*) for the repeat questions.

C. How to leave a message

If you reach the family's home but are unable to talk with the mother, leave a specific message, including a time when you will call back. A suggested message to leave with another person follows.

> *"This is YOUR NAME from the NICHD Study of Early Child Care at the University of _________. We visited with MOTHER'S NAME about ___ months ago, and I am calling to see how she and CHILD are doing. She can reach me at PHONE NUMBER and DAYS/TIMES. I know she's very busy so I'll try to reach her again. Do you know of a good time for me to call? Thank you."* (Record date and time.)

D. An alternative message for an answering machine

> *"This is YOUR NAME from the NICHD Study of Early Child Care at the University of ___________ calling for MOTHER'S NAME. We visited with you in MONTH, and I am calling to see how you and CHILD are doing. You can reach me at PHONE NUMBER and DAYS/TIMES, and I'll call back DAY/TIME. Thanks."*

E. What to do if you cannot reach the family by phone

If the family does not have a phone, their phone is disconnected, their number has been changed to an unlisted one, or after a week of trying at all times of day and evening you have not contacted the family, special efforts must be made to reach the mother. The following steps are recommended:

1. Call work numbers if available. Unless parents have explicitly asked you not to call them at work, call the work numbers for either or both parents to arrange a convenient time to conduct the interview.
2. Make a home visit. When possible, the most effective approach to contacting a hard-to-reach family is for a project staff member who is acquainted with the mother to stop by the family's home. Often, people will not have moved even if their phones are disconnected or changed to an unlisted number. The home visit should always be carried out by someone who has met the family, and preferably someone who has been to the home before (the 24-month home visitor, for example). If the family has no phone, the interview can be carried out in person, or an alternate arrangement can be made for the interviewer to collect the information from the mother. If no one is at home but it looks as though the mother still lives there, leave a letter or card asking her to contact the project office. Be sure to let her know she can call collect.
3. Call the family's alternate contacts. Alternative phone numbers which were first obtained in the hospital and/or at 1 month, and which are updated at each contact point, are useful primarily for obtaining new

addresses and phone numbers for study families. Leaving messages at the homes of alternative contacts is generally not productive, although it can be tried. Asking alternative contacts to go and get the mother while you wait on the telephone is an imposition, and is not recommended. If the alternative contact can provide a new phone number or address, follow up on that by calling or making a home visit.

4. Send a letter with the project phone number and a return postcard to the family's last known address. (Use sample letter included the 36-month Appendix.) This prompt is often enough to encourage mothers to call you, or to send you their new address or phone number. Then you can follow up with a phone call or home visit. Be sure to let the mother know she can call you collect. Mark the envelope Address Correction Requested in order to receive a new address.

5. Call directory information in surrounding areas. The family may have moved nearby and still have a published phone number.

6. Check with the post office. Provide the family's last known address to the post office and ask for the newest address for the family. The post office will charge

$1.00 per name to give the most recent forwarding address.

F. What to do if the mother says she no longer wishes to participate in the study

When a mother tells you she wishes to withdraw from participation, ask *"If you don't mind, can you tell me why you don't want to continue?"* Very politely, and without being insistent or coercive, try to reassure the mother.

If she says she's too busy, having another baby, going back to work, or just feeling overwhelmed, say *"Yes, you must be really busy, especially with all these new demands on your time and energy. We do our best to make things as easy as possible for you. These are our last visits, and we would like to schedule them at your convenience. We can work around the other demands on your time."*

If she still feels this is not a good time to be in the study, thank her for her participation and arrange to give or send her the videotape of her family.

Fill out the form for recording dropouts and send it to the Data Center.

If she says her husband/partner doesn't want her to continue, say

"What does he seem to be concerned about?"

Then listen. Acknowledge the mother's concerns. When she is done and leaves time for you, provide supportive information, and ask

"Would you like me or SITE P.I. to call him and talk with him about our study? We would be more than happy to speak with him."

Arrange a time to call if this would be helpful.

If mother continues to say she wants to withdraw, say, *"I'm sorry you feel you cannot continue. We would very much like CHILD to have the opportunity to finish participating in what we think is a very important study. But I certainly understand your feelings. If you change your mind, please call us. Again, our phone number is ____________."*

Fill out the form for recording dropouts and send it to the Data Center, and arrange to give/send the family their videotape.

G. What to do if the mother refuses to schedule one of the three visits: child care, home, lab

When a mother tells you she cannot participate in one of the visits, ask *"If you don't mind, can you tell me why you don't want to participate in the (home/playroom/child-care) visit?"*

Very politely, and without being insistent or coercive, try to reassure the mother.

See specific instructions for F above.

It is possible, for example, that the mother is uncomfortable with being video-taped at home or in the lab. Reassure her that the data will be completely confidential and that no names are included on the tapes, etc. If she remains uncomfortable, you may eliminate this portion of the visit and retain the rest. Some data is always better than no data. Also, it is crucial that we keep these families involved and invested in the study. If we are quick to eliminate an entire visit, then we send a signal that partial participation is okay.

Be sure to inquire about helping out with transportation and babysitting.

Some sites may also have a set of mothers who have participated in each assessment who are willing to talk with other mothers; sometimes the reassuring voice of a participant is exactly what is needed. Of course, you would FIRST need to ask the reluctant mother if she would like to talk to another participating mother and, if yes, does she mind if you give out her phone number. THESE COMMUNICATIONS MUST BE KEPT CONFIDENTIAL. One mother is calling another mother -- no names involved.

However, if the mother insists that she cannot participate in one of the visits (see H below concerning the child care visit), then say *"I'm sorry you feel you cannot be part of the* *(home/playroom/child-care) visit. We would very much like CHILD to have the opportunity to finish participating in what we think is a very important study. But I certainly understand your feelings. If you change your mind, please call us. Again, our phone number is _______________.*"

H. What to do if the mother says the child care provider will not participate in the study

"What does she/he seem to be concerned about?"

Then listen. Acknowledge the provider's concerns. When she is done and leaves time for you, provide supportive information, and say:

"Sometimes it helps a lot for us to talk to the provider and to answer (his/her) questions. Do you mind if we do this?"

IF NO, follow procedures for contacting the provider directly.

IF YES, ask *"Can you tell us a little about why you don't want us to call your provider?"*

Try to address the mother's concerns, but don't be so persistent as to jeopardize the mother's continuing participation in the study.

IV. RECORDING CALLS

The form labeled RECORD OF CALLS (Form 10B, Page 3) is for use at sites to keep track of all attempts to reach a mother. Every time the caller attempts to contact the mother, the date and time should be recorded and the result coded according to the codes listed at the bottom of the sheet. The interviewer's code or initials should also be marked on this sheet so that if more than one caller is trying to reach the mother, each one will know who has already left messages with the family. Any special situations should also be recorded on the reverse of this form. The Record of Calls is retained at the site in the family's confidential folder.

V. FORMAT OF THE PHONE UPDATE INTERVIEW

Every interviewer should become thoroughly familiar with the format, layout, and questions of the interview. Because of the many different situations we expect to encounter during this study, the questions have been written to try to cover a great variety of responses.

The interview consists of two sets of forms: (1) forms for recording information - the FACE SHEET, RECORD OF CALLS, CURRENT CHILD CARE GRID, PEER OBSERVATION WORKSHEET, INFORMATION SHEET FOR 36-MONTH CHILD CARE OBSERVER, INFORMATION FOR 36-MONTH LAB VISIT, AND INFORMATION FOR 36-MONTH HOME VISIT, and (2) the actual 35-month interview and script.

Within each section of the interview, there are a number of choice points when the interviewer must skip over particular questions or sets of questions because they are not relevant to a particular situation. It is important that each caller be completely at ease with these choice points so that the interview can proceed smoothly and keep the mother unaware of the many coding and question selection decisions the interviewer is making.

The conventions followed in this interview protocol are:

1. The directions to the interviewer that are not intended to be read to the mother are printed in ALL CAPITAL LETTERS. The questions and comments to be read to mothers are printed in upper and lower case type.
2. The interviewer is expected to continue to the next question unless instructed otherwise by a GO TO or choice point instruction.
3. Questions that must fit more than one situation are worded so that the choices between two wordings are in parentheses. Example: Last time we talked you (were/were not) going to school. The interviewer is expected to choose the correct wording for the particular situation, not read both options. This requires that the interviewer have the questions clearly in mind, understand the different possible situations to which they refer, and have updated information about the family.
4. Questions in which a person's name (or other specific information) is to be used indicate the missing information in capital letters, as, for example: Has CHILD had any ear infections? The question should be read as, Has Samuel had any ear infections?

VI. MARKING THE FORMS

The mark-sense forms used for the interview must be filled in carefully. Use a #2 pencil and be sure to blacken the entire space to indicate the mother's response. Whenever there are two columns of numbers, as for month and day, for example, mark both columns. If your response requires only one digit, mark 0 in the first column.

For example, to record a date of March, 1993:

MONTH		YEAR	
0	3	19 9	3
▬	0	0	0
1	1	1	1
2	▬	2	2
3	3	3	_
4	4	4	4
5	5	5	5
6	6	6	6
7	7	7	7
8	8	8	8
9	9	▬	9

Write the date in numerals on the top line, then mark the corresponding digits in the mark-sense columns below.

VII. INTERVIEW SCRIPT

The 35-MONTH TELEPHONE INTERVIEW has been used at several time points. It is essential that the boxes indicating the correct time point be marked at the beginning of the phone call. Use the introductory script, and at 36-months you will need to add that we are also interested in some information about children STUDY CHILD plays with. At the beginning of the interview, you may also find it helpful to add some informal conversation with the mother to make her feel comfortable, but do not spend too much time chatting before getting down to work. The mother appreciates your friendliness but will also appreciate not being kept on the phone too long.

Once you begin the questions, they must be read exactly as they are written, with two exceptions: (1) You will have the occasional situation where the information requested is obvious or already known to the interviewer. In these cases, the interviewer may reword the question as a statement, confirming with the mother that the information obtained previously is accurate. (2) The use of the term "arrangement" seems too formal for the type of care being discussed. This is likely to happen with father care or when mothers are child care providers. In these situations feel free to substitute language such as, "How many hours a week does your husband take care of Sam?" For a few questions (e.g., Q39), alternative wordings have been provided.

Mothers have different ways of responding to interview questions. Some are very precise and specific, but others tend to give vague responses or answer in general ways that are not codable. You can encourage mothers to be more specific by enlisting them as partners in the process of data collection. For example, if a mother responds to the question,

"*How many hours a week do you work?*"

by saying

"*15 or 20 hours.*"

you can say,

"I need to record a specific number of hours. Please give me your best estimate of the number of hours you work in a typical week."

The next time the mother responds with a range of numbers instead of a single answer, follow the same procedure. Usually after two reminders, mothers will understand the requirements of the interview and begin to give you codable responses without prompting.

Finally, this interview requires some flexibility in wording, especially when obtaining the information about current care arrangements and completing the grid (questions 26-37), given the wide range of possible responses. The important thing to keep in mind is that you need to get all of the information requested to complete the grid. You will not always need to ask each question. For example, if you know that the mother is the child care provider, you do not need to ask about the sex of the provider. Use common sense!

VIII. INTERVIEWING TECHNIQUES

Be sure to read all questions exactly as they are worded. If the wording seems awkward to you, practice saying the questions aloud until you feel comfortable with them.

On some occasions, mothers may volunteer information during one part of the interview that you will ask them for later. Remember what they have said, but do not flip through the interview pages to record that information. Instead, when you come to the relevant section, confirm the information you have received and ask, "*Is there anything else?*" For example, after asking the mother the first question about use of regular child care, she may volunteer that she takes CHILD to a day care center. Then, when you get to Question 26 you can say, "*You mentioned that you take CHILD to a day care center. Who takes care of CHILD there?*" But don't forget to probe for additional arrangements. Whenever you are confirming information with the mother, use the wording of the question as written to the greatest extent possible. It is essential that you cover the content of every question. Do not assume information without confirming it, even if it seems self-evident.

Because the interview cannot exactly fit every possible situation for all the mothers in the study, there will at times be questions that seem inappropriate. In these unusual cases, you can say something like, "*The next question asks...*" Done politely and without belittling the question, this approach lets the mother know you are attuned to her individual situation, but also that you have a job to do and you take it seriously.

Do not interpret or reword questions. If a mother asks for clarification of a question or word, try repeating the question, perhaps with a slight change in intonation. Sometimes mothers may ask the meaning of a question that has a set of multiple choice answers. In this case, you can read her the options so she can select one of the choices.

IX. PREPARING THE MOTHER FOR INITIAL CONTACT WITH PROVIDER

During the phone call with the mother, tell the mother that you wish to visit and observe the child in his/her child care arrangement; tell her in general the purpose of the observation, what you hope to find out, and how you will do it. Usually, you will then ask the mother's permission to contact the care provider directly about the visit (the program director or, in non-center based care, the child care provider). In some cases, though, it may be the better part of valor for the mother to approach the care provider first. Use your judgment; the important thing is to obtain the consent for the visit -- whatever it takes. If she wants to, the mother can mention to the caregiver that we will be calling him/her, and then leave it to you to seek permission to visit. Alternatively, the mother may want to handle setting up and scheduling the visit herself. Or, finally, what may work best is for the mother just to give you the provider's name and for you to take it from there.

If the mother opts to be the person to contact the caregiver, you will schedule a call-back (as soon as possible, but no more than 10 days after the initial call) and inquire about her contact with the provider.

Successful contact: Thank the mother for her assistance and proceed to provider contact.

Unsuccessful contact: In some cases, the provider will tell the mother that he/she does not want to be contacted by the research team. Try to find out why this has occurred. In some instances (e.g., the mother thinks the provider is wavering), you may deem it appropriate to contact the provider anyway, but be sure to ask the mother's permission to do this. In other instances, both mother and provider will be adamant about refusing the child care visit. If the child does not have a secondary arrangement in which he/she is enrolled for at least 10 hours a week, we have a missing child care observation. If there is an appropriate secondary arrangement, ask the mother if we can repeat the recruitment process for this provider.

PROBLEM SOLVING: If the mother seems reluctant to talk to the provider about the visit (or to have you contact the provider) or to have the child observed in child care, ask her why. If possible, use one of the following suggestions to address specific concerns:

A. The mother feels the child has not been in the arrangement long enough. Explain we do not observe a child unless he/she has been in the child-care arrangement for at least 2 weeks. Our experience has shown us that for our purposes, this seems to be enough time for both the child and caregivers to adjust to a new situation.

B. The mother feels the observations would be asking too much of the provider. If the mother is concerned because the observer could be intrusive or disruptive, explain that we will describe the study in detail to the provider, and arrange times for the visits that are convenient to the provider. Mention that we tell the provider not to make any special arrangements, and that we will respect the routines and responsibilities of the caregivers during the visits. If it seems appropriate, mention the observers' extensive experience and training. Also emphasize that after we explain the study to the provider, we ask for the provider's separate consent to participate in the study.

C. The mother feels the study would not be of enough interest to the provider. Explain that we will send the provider information about the study before calling, and emphasize that observing the child when he/she is away from the mother is important to our understanding of how a child develops. Tell the mother that we will explain to the provider that his/her participation is important and valued. Mention that the provider will be asked for separate consent after the study has been explained by the project staff.

D. The mother feels the caregiver would be reluctant to have an "outsider" judge the quality of the caregiving environment. Explain that any observations are confidential and will only be shared with the project staff (except in cases of child abuse). If the mother inquires now or at any time if we will report back to her about the caregiving arrangement, tell her "*No, our observations are confidential, just as all the information that you give us is confidential. Of course, overall study conclusions will be shared with you and any interested caregiver.*"

E. The mother suggests that she get the provider's permission before we call. Accept her suggestion, and advise her to reassure the caregiver of the unobtrusiveness of the researcher, the importance of the study, and so on. Also emphasize the need to make arrangements within the next week or two.

No contact: If the mother has not contacted the provider during the 10 days after the phone call, ask her why. If possible, use one of the following suggestions to address specific concerns:

A. The mother simply forgot to contact the provider. Emphasize that it is very important that she do this in the next day or so, in order for us to have time to contact the provider and schedule the visit. If after three contacts by the project staff the mother still has not contacted the provider, probe as to why, and follow problem -solving suggestions below (B. and C.).

B. The mother has changed her mind about consenting to the child-care visits.

1. If the mother seems ambivalent or is unwilling to discuss her refusal, probe for the reasons for her reluctance. See problem-solving suggestions from pages 27-29 to handle concerns.

2. If the mother is definite in her refusal and does not want to discuss her decision, we have a missing child care observation. The mother, however, may still be open to allowing the peer play observation. Proceed to Part 5D of the 35-month call manual.

C. The mother suggests that we make the initial contact ourselves. We agree to do this and follow provider contact procedures.

X. PRIMARY CHILD CARE ARRANGEMENT: DECISION RULES

Each site is provided with two copies of this page summarizing the decision rules. Post a copy by each phone from which the 35-month calls will be made.

PRIMARY CHILD CARE ARRANGEMENT:DECISION RULES

Child must be in the primary arrangement 10 hours a week or more (Q32), typically awake for 3 hours on days used (Q33), and must have been enrolled for at least 2 weeks prior to the child care visit (Q36 gets age in months when enrolled. We will confirm the 2-week requirement when the child care visit is scheduled).

If mom cares for child at home (Q19[1]), other non-sibs who live in another household must be present 20 hours per week (YES to Q20, Q21, and Q22).

If mom takes child to work (Q19[2]), she must work in a child care center (Q23[1]) or another adult must regularly spend 10 hours per week with baby as a sitter (YES to Q25).

When multiple arrangements meet these criteria: (Use these decision rules hierarchically.)

1. Use arrangement with most hours of care per week (see Q32), including only those arrangements where child is typically awake for at least 3 hours.
2. If comparable hours (plus or minus 5 hours per week), use most "formal" arrangement: group program, home-based program, non-relative, relative other than father, father (see Q26).
3. If comparable hours in same type of arrangement, use arrangement in which child has been enrolled the longest (see Q36).
4. If all else is equal, use morning arrangement, unless BABY has been enrolled in afternoon arrangement for at least one month longer (see Q34).
5. If all else equal, pick primary arrangement randomly.

XI. FACE SHEET

The face sheet for the telephone contact (labeled INFORMATION FOR 35-MONTH TELEPHONE INTERVIEW) is for use by the project staff at each site to help keep track of the information needed in the interview. This sheet is not to be sent to the Data Center. It should be filed in the family's confidential file.

Before calling, complete in all of the indicated information on the face sheet. Use the information collected at the most recent contact to fill in these pages. Also, use this information to fill in question 1 (Form 10B, Page 1 of the interview) before calling.

During the call, you will get information on changes in addresses, phone numbers, and contact persons. Write this new information on the face sheet.

When making calls, record the date/time and results of each call on (Form 27C) Page 3 (labeled RECORD OF CALLS). This form should not be sent to the DCC; it should be filed in the family's folder.

A page in mark-sense format (labeled 35-MONTH TELEPHONE CONTACT) is inserted as Page 2 of Form 10B. At the completion of the interview, fill in this form completely, with date of interview, interviewer's ID number, child's ID number and relationship code, and child's age in months.

Once the interview is completed, separate the site face sheet (Page 1 of Form 10B) and the RECORD OF CALLS (Page 3 of

Form 10B) from the interview itself and file them in the family's confidential folder. Have the interview forms checked by the site coordinator or his/her designate before they are sent to the Data Center.

XII. CURRENT CHILD CARE ARRANGEMENTS GRID (Form 10A)

Before calling, have the CURRENT CHILD CARE GRID in front of you. You will fill it in as you reach Questions 26-37 in the interview. You will rely on this form to determine whether the child is in a child care arrangement that will be observed at 36 months. This is sent to the Data Center. Be sure to fill in the ID number and indicate which age (month) data are being collected.

XIII. PEER GRID AND PEER INFORMATION WORKSHEET

Keep the PEER GRID and the PEER INFORMATION WORKSHEET in front of you and use them to record the information about appropriate peers that you will obtain from the study child's mother during the Peer information interview, Part 5D of the 35-month phone call. Use the PEER GRID to determine whether a suitable peer is available. On the PEER INFORMATION WORKSHEET, you will record contact information for getting consent for the peer's participation and the location where the study child and peer regularly play. The PEER GRID and the PEER INFORMATION WORKSHEET remain at the site for scheduling and is eventually filed in the family's confidential folder.

XIV. INFORMATION SHEETS

The 35-month telephone contact packet includes several forms (INFORMATION FOR 36-MONTH LAB VISIT, INFORMATION FOR 36-MONTH CHILD CARE OBSERVER, INFORMATION FOR 36-MONTH HOME, EXPECTED CHILD CARE AT 36 MONTHS, Peer Observation Worksheet) that are designed to prepare you for the next steps in the study, whether they involve a call-back, the 36-month home visit, the 36-month lab visit, peer observation or the scheduling of a child care visit at 36 months. These are not to be sent to the data center. They can be used to notify project staff of upcoming appointments and are to be filed in the family's confidential file.

A. Child Care Observer

Before calling, have a CHILD CARE GRID and an INFORMATION FOR 36-MONTH CHILD CARE OBSERVER in front of you. For families who are not using or expecting to use child care at CHILD's 36-month birthday, you will fill in the child ID#, phone number, date/time of 35-month call, and interviewer; circle (2) for Primary child care arrangement; and record the date and time of the 36-month home visit(s) and the 36 month lab visit. For families who have a Primary child care arrangement, you complete all of this information, but circle (1) for Primary child care arrangement, and complete the information about the arrangement to be observed at 36 months.

For families who expect to be starting or changing child care when the CHILD is 36 months old, you will circle (3) for

Primary child care arrangement, fill in the date and time of the call back on the RECORD OF CALLS form, and transfer the information about expected arrangements (Question 46 of the interview) to INFORMATION FOR 36-MONTH CHILD CARE OBSERVER for reference at the call back.

Finally, for those cases in which the mother wants to make the first contact with her care provider, you will need to write the date and time of the call back on Page 13, and give this call a code of (4) on the RECORD OF CALLS (Form 27B), indicating the time and date to call there as well.

B. Peer Interaction Observation

During Part 5D of the 35-month call, use the PEER GRID and the PEER INFORMATION WORKSHEET to determine whether an appropriate peer is available and to record contact information about peers who meet our criteria for observation and the location of the setting where the target child and peer play together.

If the study child's mother is making the first contact with the peer's family or needs time to obtain information about the peer, record the date and time you arranged to call the mother back on the PEER INFORMATION WORKSHEET and on the RECORD OF CALLS form.

If the peer interaction observation is to take place at the target child's regular child-care setting, record this on the INFORMATION FOR 36-MONTH CHILD CARE OBSERVER form.

C. Home and Lab Visits

INFORMATION FOR THE 36-MONTH LAB VISIT AND INFORMATION FOR THE 36-MONTH HOME VISIT are notification sheets to help you keep track of home and lab visit information. These sheets should be filled out after the interview and may be used to coordinate these visits at your site. They are not sent to the DCC but should be kept in the family's folder.

XV. AFTER THE INTERVIEW

A. Scheduling Child-Care Visits

For families who are using child care that fits our criteria for observing, one of two procedures will be followed to schedule the child care visits:

1. PREFERRED: The mother gives you permission to contact the provider directly. In this case, send the mother the letter in Appendix A2, which briefly describes the child care visit.

2. The mother first contacts the provider. In this case, you will send the materials in Appendix A3, A4 and A5 to the mother. These are: (a) a letter to the mother which briefly describes the child care visit and tells her or him what to do with the enclosures, (b) a list of points that the mother should be sure to mention to her provider when she talks to her about participating in the study, (c) a letter to the provider that the mother may or may not choose to mail or give to the provider, and (d) an enclosure for the provider letter which describes the overall study. PUT THE LETTER TO THE PROVIDER AND THE STUDY

DESCRIPTION IN A SEPARATE ENVELOPE AND ENCLOSE IN THE PACKET TO THE MOTHER.

B. Getting Consent for Peer Interaction Observations

If one or more peers meeting our criteria are identified during the 35-month call, use one of the methods outlined in PART III of the Peer Manual to obtain consent for the peer's participation in the observation.

REMEMBER

BEFORE YOU CALL:

1. Complete the INFORMATION FOR 35-MONTH TELEPHONE INTERVIEW (Form 10B, page 1)
2. Transfer all information about child care arrangements to Question 1 of the 35-month Telephone Interview.
3. Know the mother's and baby's names. If your site is participating in the HHS Fathers Study, know the father's name and whether the parents are married (so you can use "husband" or "partner" appropriately).
4. Tear out INFORMATION SHEET FOR 36-MONTH CHILD CARE OBSERVER and have a CURRENT CHILD CARE GRID available. You will be filling these in during the interview.
5. Have the decision rules for determining an observable primary child care arrangement posted by the phone and memorized.

6. Be familiar with the various skip patterns and Check Points of Parts 5D and 5E of the 35-month phone call. You will need these, as well as the Peer Grid and the Peer Information Worksheet in order to continue the interview to determine if there are available peers for the observation.

XVI. FLOW CHART OF THE INTERVIEW PROCESS

PART 1: INTRO

PART 2: STOPPED CARE?

PART 3: SICK CARE

PART 4: CURRENT CARE

PART 5: IDENTIFY PROVIDER

PART 5D: INTERVIEW TO DETERMINE THE AVAILABILITY OF PEERS

PART 5E: COMPLETING THE PEER INFORMATION WORKSHEET

PARTS 6 & 7: SCHEDULE HOME AND LAB VISITS

PART 8: COMPLETE INFO SHEETS FOR OBSERVER, FORM 10C

XVII. THE INTERVIEW FORMS

The following sections of this manual provide specific information about the questions included on the phone update interview. Callers should read through this section of the manual regularly to be sure they are thoroughly familiar with all coding rules and with the format of all questions and answers.

Part 1: INTRODUCTION

This section introduces you and the interview to the mother, and obtains any updated information about addresses and phone numbers. Any changes must be recorded on the INFORMATION FOR THE 35-MONTH INTERVIEW form (Form 10B, page 1). Be sure to add that you will be asking information about children STUDY CHILD plays with.

There are two YES/NO questions on page 1 after the introduction. They pertain to unusual changes in the child's routine, separations, and other unusual circumstances. They should have been placed on page 17, when you are scheduling the lab visit.

Part 2: STOPPED CARE?

Question 1

To link this interview to the prior 33-month phone interview, we start by inquiring about changes in child care arrangements since that contact. The interviewer should have filled in any relevant information from the Fact Sheet (Form 10B, page 1), and should be prepared to remind the mother of what she said about child care at the 33-month call.

Note that there are two options for phrasing the question, corresponding to mothers who were and were not using child care at the 33-month call. Although it seems a little awkward, the interviewer must proceed, in both cases, to ask about changes. It is possible, for example, that a mother who did not use child care when the child was 33 months old started to use care briefly thereafter. In this case, she would say "yes" to Question 1.

Code "yes" if any arrangement was discontinued, even if it lasted only a very brief while.

Question 2

See Question 26.

Questions 3 and 4

See Questions 30 and 31.

Question 5

See Question 32. In cases where the hours changed in the time this arrangement was used (e.g., gradual shifting from part-time to full-time care), use the most recent hours.

Questions 6 and 7

See Question 36.

Question 8

See Question 37.

Question 9

This question is designed to assess whether this was an anticipated and/or planned change in arrangements, or whether the mother was caught by surprise or affected by events beyond her control and thus HAD to change arrangements. ASK THE QUESTION AS WORDED. If the mother answers "yes" or "no", accept her answer, regardless of the following guidelines. If she is unsure and explains her situation then and only then should you use the decision rules, below, that define "planned" vs. "unplanned". The bottom line is to go with the mother's perception of the change as planned or unplanned.

Here are some examples and guidelines for cases where the mother cannot tell you if the change was planned or unplanned. If a family day care provider stops providing care, for example, this would not be a planned change. If, however, the mother decides that she does not like the provider and therefore chooses to leave, this is a planned change.

Other examples of unplanned changes include, the child being asked to leave an arrangement (some centers will not tolerate "disruptive children"), the family moving to a distant part of town unexpectedly, or another child joining the child care whom the mother dislikes and therefore she changes arrangements.

Other examples of planned changes include switching from a grandparent to a center so the child can have more social interaction, changing arrangements because something more convenient or affordable is found, or changing because a friend has a baby and the mother decides to share care.

Part 3: SICK CARE

Ask the questions in this section only if the child was in some form of child care at the 33-month call. You can determine this from the Face Sheet (the mother indicated a child care arrangement at the 33-month call). We realize that we may miss situations in which the child started care right after the 33-month call, but these are likely to rare and you won't learn this until you get to PART 4 of this interview. We do not expect or want you to have to back track to earlier questions as you proceed through this call.

Questions 10 and 11

When a baby is sick, mothers often have to piece together a patchwork of care. Record one or two emergency arrangements the mother made. Since mothers may use child care for any reason, we want to know if the CHILD has been sick when the mother typically relies on child care for any reason.

Question 12

PLEASE REWORD this item to read, "In the last 2 months, have you or your (husband/partner) missed work, school, or another regularly scheduled activity because of a problem with your child care arrangement?"

Missing work means a significant amount of work. Code Yes if one parent missed a half day or more, or missed an important work obligation, such as an important meeting, appointment, or business trip.

Question 13

Ask as an open-ended question and code if possible. Read the list of possible problems if the mother does not immediately volunteer a codable response. Only ONE response may be scored.

Part 4: CURRENT CARE

This section obtains information about the family's current reliance on child care. Families who are using child care will fall into two groups: (1) those for whom at least one arrangement meets the decision criteria for observing the child in care at 36 months, and (2) those for whom none of the arrangements used meet the decision criteria. Recall that we are collecting child care information on both types of families.

This is also the section where the CURRENT CHILD CARE GRID is completed (see Questions 26-37).

Question 14

The major purpose of this interview is to get information about the family's regular child care arrangements. Regular means that the mother has some standing arrangement with another person to care for the child at a specified time every week. This may include short periods of babysitting. For example, if the mother has a regular evening or Saturday afternoon when her husband/partner is expected to be responsible for the child, this is a regular arrangement. Also, if the mother leaves the child with her mother every Thursday afternoon, or expects an older sibling to be responsible for the child from 4:00 to 5:00 every day, these count as regular arrangements. If she occasionally hires a sitter to go out in the evening, this is not a regular arrangement. Nor are arrangements that occur on a non-weekly basis. For example, if a mother-in-law comes one week a month to care for the child, we are not considering this to be child care. Be careful not to confuse regular with the criteria for scheduling a child care observation. It is entirely possible for a family to have a regular arrangement that does not fit the criteria for observing. For example, a sitter who comes 2 days a week for 4 hours each day does not meet the minimum of 10 hours a week for scheduling an observation, but this is a regular arrangement.

Question 15

PLEASE REWORD this item to say, "Do you expect to start using regular care (to be working for pay or going to school) between your child's 35 and 38 month birthdays?

Because we are calling the families at 35-months, but making our child care observations at 36-months, it is possible that a few families will be starting child care between this call and the child's 36-month birthday. This question is designed to flag these families, and is asked only if the family is not currently using child care (NO to question 14). This may happen, for example, if the 35-month call falls during the summer for a child whose mother is a school teacher. The mother may not work during the summer and thus may not keep the child in child care. If this child will re-enter child care at any time during the window or exception period for the 36-month child care visit, we want to conduct this visit. If the mother responds "yes" to this question, skip to Question 46, which gets information about her child care plans, and then SCHEDULE A CALL-BACK as soon as such a call-back makes sense in light of the mother's plans.

Question 16

Some mothers may not consider themselves to be using regular child care and so answer "no" to question 14. But, in fact, they are working or going to school, in which case we want to know what they are doing about child care. If a "yes" answer is given, skip to question 18 (hours of work/school) and then inquire about child care (question 19).

Question 17

PLEASE REWORD this item to say, "Do you expect to start using regular care (to be working for pay or going to school) between your child's 35 and 38 month birthdays?

This is similar to Question 15. Some mothers will resume work between their child's 35 and 36-month birthdays, but will still answer "no" to question 15. This question assures that we will get information about how they plan to handle child care if they are returning to work in the next month. Again, if the mother responds "yes" to this question, skip to Question 46 and then SCHEDULE A CALL-BACK.

Question 18

This question is asked only of mothers who do not respond "yes" to question 14, but indicate that they are working now or going to school (Question 16). If the hours per week vary from one week to the next, ask the mother how many hours she worked or went to school "last week".

Question 19

This question is asked of mothers who did not say "yes" to having a regular child care arrangement (Question 14), but who are now working or going to school ("yes" to Question 16). Ask this as an open-ended question. The mother may respond with a non-maternal child care arrangement, such as "My husband takes care of CHILD." Code this as "3 Other" and complete Question 26. Similarly, the mother may say, *"Oh, my mom comes over and watches CHILD."* Code this as "3 other" and complete Question 26. But the mother may indicate that she takes care of the child while she is working and would have probably said "no" to Question 14. If this is the case, two options are possible. The mother may work at home and care for the child at the same time (code as "1" and GO TO Question 20). This will be the case for mothers who provide family day care in their own home, as well as for mothers who are, for example, private consultants and who work out of their home and decide not to hire anyone else to provide child care. Alternatively, the mother may take the child to her out-of-home job and either watch the child full time or rely on someone at the work site to watch the child at least part time (code as "2" and GO TO Question 23).

An important, complicated situation. There are two situations that should be coded and queried as "mother care" arrangements that may not be caught as such initially.

1. Mother as "helper" in family day care home, or teacher in CHILD's center classroom. If the mother works in a day care arrangement, and cares for her child along with other children, and works with other providers, she will say "YES" to Question 14. You then skip to Question 26. The mother's response to Question 26 will include herself (0), and some other adult(s). You will also learn, for question 27, that this care occurs in (2) someone else's home or (3) center/nursery. In this case, you should go back to Question 19 and code this as (2) Take baby to work, and complete questions 23 and 24. Then, continue with the GRID questions (27-37).

2. Mother as in-home provider with a helper. If the mother works in her own home and takes care of other children, and hires a helper, she will say "YES" to Question 14. You then skip to Question 26. The mother's response to Question 26 will include herself (0), and some other adult(s). You will also learn, for question 27, that this care occurs in (1) child's

home. In this case, you should go back to question 19 and code this as (1) Work/Study at home, and complete questions 20, 21, and 22. The mother will, in all likelihood, respond "YES" to all of these questions, you will then proceed with Question 27 (not 30, in this case, as instructed in Question 22).

Questions 20, 21, and 23

If the mother is taking care of her child while working/studying at home, the three conditions described in questions 20, 21, and 23 MUST BE MET before we will observe this arrangement as a child care arrangement. Specifically, unrelated children (Q20), who live in another household (Q21), must spend at least 20 hours per week with the mother and child in a typical week (Q23) for us to observe this as a child care arrangement. A response of "no" to any of these questions ends this part of the interview and you go to Part 5D, the PEER INFORMATION INTERVIEW to determine the availability of a peer for observation.

It is important to note that some children will have siblings who live in a different household and who come to the mother's house during the day. We will NOT observe these arrangements, because we consider mother and siblings to be a primary family unit. However, if the child has a cousin who lives in a different household and comes to the mother's house during the day (20+ hours per week), we DO observe this arrangement. Basically, we consider these mothers to be family day care providers.

Questions 23, 24, and 25

If the mother takes the child to work with her, we will observe this as child care IF the mother is a child care worker and the child comes to her center (Q23[1]) OR the mother has another form of employment (Q23[2]) in which she brings the child to work, where an other adult routinely watches CHILD for 10 hours a week while the mother is doing other things ("Yes" to Q25).

If the mother is a child care worker, we find out if the child is in her classroom (Q24). If she answers "yes", GO TO question 26 and, working with the GRID, ask if anyone else takes care of the child. There may be more than one child care provider for the infant classroom, for example, in which case you would code (0) mother and (7) unrelated adult (assuming the provider is unrelated) for 26. If she answers "no", GO TO question 26 and ask as worded: Who takes care of CHILD? Obviously, in both of these cases, you can code 27 as 3 and 28 as F, but 31 will vary depending upon whether only the mother, only another provider, or both provide care.

If the mother brings the child to work and another adult watches the child for 10+ hours per week (even if it is the father), GO TO question 26 to find out who this other adult is and whether he/she lives in the child's home or not. You can code 27 as (4). If the mother brings the child to work and the criterion for observation is not met (no other adult watches the baby for 10+ hours per week), then you need to go to Part 5D, PEER INFORMATION INTERVIEW and determine the availability of a peer for observation.

USE OF THE GRID (Questions 26-37)

The interviewer will have the grid placed in front of him/her. All responses to Questions 26-37 are recorded on the grid. This will greatly facilitate the process of determining whether the child is in an arrangement that meets the criteria for observing at 36 months and, in the care of multiple arrangements, which one to observe. It will also help in identifying peers for observation (see Q30). For families with one observable arrangement, the interviewer should also complete the GRID section of the INFORMATION SHEET FOR CHILD CARE OBSERVER.

Question 26 and 27: Coding Child Care Arrangements

You will obtain this information by asking open-ended questions: Who is caring for the child? You will need to probe after the mother gives you one arrangement, to make sure that she is not forgetting to tell you about additional arrangements.

Mothers will answer the questions about child care arrangements with more conventional descriptions (babysitter, nanny, etc.). The responses on the interview form are not intended to be read to parents. Instead, they are for your use in coding the type of arrangement the parents have made for child care. Thus, if the mother says they have found a sitter, you will need to ask if the sitter is a relative, whether he or she will be coming in to their home or they will be taking the child to the sitter's home, and whether the sitter lives in the child's home or elsewhere.

Be sure to code all arrangements, even if some of them are informal, such as the child's father staying home until 9:00 every morning. Although many mothers will not think of this as a child-care "arrangement", it is to us. Use Arr. 1 for the arrangement used for the most hours, Arr. 2 for the next, and Arr. 3 for the third. Do not code more than three arrangements.

Please code stepfathers as 1=Child's father/mother's partner.

If the mother begins to tell you about future plans, explain that we will be asking about this at the end of this interview (see Question 45).

It is a good idea, in the case of multiple arrangements, to let the mothers describe the situations and code the information while she is talking. Then go back and confirm the information and fill in any gaps before proceeding.

Sometimes it will be difficult to determine whether a particular situation is one or two arrangements. For example, if a child has a non-related sitter who comes into the child's home 3 days a week and cares only for the study child, and the same sitter takes the child along with her to a different child's home for 2 days a week (thus caring for two children on these two days in the other child's home), this counts as two arrangements, as follows:

Arrangement 1: WHO? = 7) Unrelated adult
WHERE? = 1) In baby's home
LIVE IN? = No

Arrangement 2: WHO? = 7) Unrelated adult
WHERE? = 2) In someone else's home
LIVE IN? = No

This counts as two arrangements, because you are not able to give more than one response for #27 WHERE? and, therefore, could not accurately code the relevant information as one arrangement. It is also important to code this as two arrangements because you will have two different responses for Question 30 (Arrangement 1 = 00; Arrangement 2 = 01).

Similarly, the CHILD may be cared for alone by a sitter on Monday and Wednesday at the baby's home, but be joined by her 3-year-old sister on Tuesday and Thursday. Again, this would count as two arrangements, both coded as WHO? = 7, WHERE? = 1, LIVE IN? = No, but coded as 00 and 01 for Question 30.

It is also possible that some mothers who use their husbands/partners for child care will say "no" to Question 14, "yes" to Question 16, and will indicate for Question 19 that the husband/partner helps her with child care while she works (thus, Question 19 gets coded as (3) and you skip to Question 26). GO

BACK TO Question 14 and score YES. You may then restate Question 26 as a statement: *"CHILD's father/your partner will care for CHILD. Where will they be? Does he live in CHILD's home?*

Examples of probe questions to ask:

Mother's Response	Query
"My neighbor is caring for CHILD.	1) *"Is your neighbor related to you?"* IF NO, code 6 for Q26. IF YES, *'What relation?"*
	2) *"Is CHILD cared for at your neighbor's house?"* IF YES, code 2 for Q27. IF NO, *"Where is CHILD cared for?"*
	3) *"Does your neighbor care for CHILD during all the hours you work?"* IF NO, *"What other child care arrangement do you use?"*
"My church has a nursery that I use."	1) *"Who cares for the children in the nursery?"*
	2) *"Is the nursery open during all the hours you work?"* IF NO, *"What other child care arrangement do you use?"*
"My husband is taking time off when I'm working."	1) *"Does he care for CHILD at home?"*

	2) *"Is he able to care for CHILD during all the hours you work?"* IF NO, *"What other child care arrangement will you use?"*
"I've hired a nanny."	1) *"This is someone who comes to your home to care for CHILD?"* IF NO, *"Where is CHILD cared for?"* 2) *"Is this person related to you?"* IF YES, *"What relation?"* 3) *"Will the nanny live in your home?"*

Questions 28 and 29

For families using child care that is not observed, Question 28 is the only source of data about gender of the caregiver. Obviously, you will use confirmatory language if you know the father or grandmother provides child care. Question 29 enables us to distinguish nannies from out-of-home providers.

Questions 30 and 31

PLEASE REWORD Question 31 to read, "Over the course of the day (and/or night), how many people supervise CHILD?"

Some mothers, particularly those who use group care, will tell you that they don't know how many other children are in the classroom, or how many people supervise her child. Ask her for an estimate. If she says she has no idea at all, leave this question blank.

The purpose of these questions is to find out how many other children are usually present when the child is in the care setting, and how many regular caregivers the child has. In a day care center record the number of children in the child's group or classroom, not the number in the whole center. In both centers and homes, the number may change during the day. Ask the mother for the typical number present during the majority of the time the child is in the setting. For example, if three kindergarten children are cared for by the child's caregiver from 4 p.m. on, but the target child is cared for from 8:00 to 5:00, do not count these children as part of the typical group. Base the typical group on the current situation; group sizes will also change seasonally.

In counting caregivers, ask the mother for the number of different people who supervise the children on a regular basis. For example, if the child's group has a head teacher who is present all day, two assistants in the morning and two different assistants in the afternoon, the number of people supervising the children is five. If a home child care provider has a teenager or another adult who regularly assists with the children, and the caregiver's husband is in charge every day after 4:30, the number of people supervising the children is three. Don't count music teachers, etc., who come in one or two times a week.

Remember that we will actually observe staff-child ratios during the child care visit at 36 months. The responses to these questions will not serve as estimates of staff-child ratios.

Questions 32, 33, 34, and 35

These questions are intended to get at the pattern of child care as well as the total number of hours. Thirty hours divided over 3 days is a different experience for the child than 30 hours divided over 5 days. In cases where the baby's schedule changes from week to week, ask the mother for the "most typical" situation in her opinion. We will obtain more detailed information about schedules when we do child care visits. If the word "arrangement" is awkward for the situation of the family you are interviewing, reword Question 32 to say, for example, "*How many hours a week (is CHILD/will CHILD be) cared for by your mother?*"

Question 33 is important for the determination of whether to observe the child in child care. If the mother says "it varies a lot", you can ask specifically if the child is awake 2 days a week for 3 hours a day. This will make the observations feasible. If you get an indication that you cannot count on this amount of awake time, then mark "no", and it is not an arrangement that we will observe.

For Question 34, you can mark more than one response. For example, if the child is in a day care center from 7 am to 6 pm every day that this center is used, then code 1 and 2 for this arrangement. If, however, the child goes to the center in the morning on some days and in the afternoons on others, then code as 5. Thus, "times vary" means that, for a single arrangement, the hours that the child spends in this arrangement are not consistent from one day to the next over the course of a week.

For Question 35, count a portion of a day as a day.

Question 36

Get the mother's best estimate if she cannot remember.

For responses in days or weeks, round up to months, e.g. 6 weeks = 2 months.

Question 37

Ask this as an open-ended question. If the mother's response clearly fits one category (e.g. "I really wanted CHILD in her own home" = 8), code it as such. If it could fit several categories, read the relevant categories and ask the mother to choose one (e.g., "Only someone like Granny could really take good care of CHILD." Ask, "So would you say the quality of the care provider is the most important reason, or that your preference for a relative to provide care is the most important reason?"). If the mother gives more than one answer that fits more than one category, you'll need to ask her to give you one response. Say, "What would you say was the most important reason?" Write in what the mother says if you code her answer as (11) Other.

Skip questions 38-41 if mother is an in-home child care provider.

Question 38

If the mother pays a daily or monthly rate, record what she tells you and later calculate a weekly rate. Do not take up interview time to make these calculations. If the mother has one or more arrangements that you think may be free (father or grandmother, for example), you can phrase the question more as a confirmation: "*And our next question is how much you pay for this care.*" Mothers will typically let you know if there is no cost. If they are not paying, record 00. If the mother is using multiple arrangements over the course of a week, but gives you a weekly rate, ask her to give you the amount she pays each week for each arrangement.

Question 39

These questions pertain to any other children of the mother. So, the first question is most accurately stated as "Does this amount include any other children of yours." If mothers are not paying for care, rephrase Question 39 as: "Does this care include other children of yours?".

Question 40

Be sure to count children other than the study child.

Question 41

Be sure to get information only on current support. If you know the parent is receiving free or very low cost care (from Question 38), you can confirm that situation. Responses 2, 4, 6 and 8 refer to "low-cost or free" care. Low-cost, in this context, means that the child receives subsidized care so that the parents are not paying the full cost. Some parents do not pay anything for child care. They get free care because they are fully subsidized by a government program (#2) , by their employer (#4), or by an agency (such as a social services agency) (#6). In other cases, a relative or friend of the child will provide child care free of charge. In these cases code #8. Also, use response [8] for a family who has worked out a cooperative child-care sharing arrangement with another family and so are not paying for care. Response [3] includes mothers who are child care providers in centers that offer free or reduced-fee care to their staff. Response [7] indicates that a relative or friend is providing money to pay for child care.

If parents reply that they receive no financial help, ask, "Do you plan to claim a tax credit for child care expenses?" If the mother says yes, record the response as [9]. Some states, as well as the federal government , offer these tax credits/deductions for child care. Some mothers may say that they receive no financial help and they are not claiming a tax credit, but their employer is allowing them to set aside up to $5,000 of her taxes before income to help pay for child care. These Dependent Care Assistance Plans are becoming increasingly common. The money that is set aside does not count as taxable income, therefore this is a form of tax subsidy for child care. Code this as [9]. Option #10 is coded when the family pays the full cost of care (no tax credit or deduction issued).

Questions 42 and 43

These questions are designed to measure the mother's satisfaction with her current child care arrangement -- not the generic type of arrangement, but the specific provider(s) that she is now using. Read the responses and ask the mother to choose ONE. For Question 43, if she says that she would not recommend to her friend that she use her provider because she does not want to share care, explain that you want to know how satisfied she is with her current arrangement, and this is one way of asking this -- you don't mean to imply that she would have to share care.

If the child is receiving care from a relative or close friend, particularly the father, this is a difficult set of questions, particularly for Question 43. In these cases, it is fine to say, "*Based on your experience, what would you say to a friend who wanted to make the same type of arrangement that you have made.*"

Question 44

Omit saying, "That's almost everything" as you still have several more questions about peers. Write down whatever the mother says.

Questions 45 and 46

PLEASE REWORD this item to say, "Do you expect to change your current child care situation between your child's 35 and 38 month birthdays?

These questions will tell you if you need to schedule a call-back because the child will be in a different child care arrangement when she/he is 36 months old. For Question 46, see Question 26, 27, and 29, with the addition of a "don't know" code.

Part 5: IDENTIFY PROVIDER

At this point in the call, you need to determine whether the target child is in an observable child care arrangement. Some children will be in care that is not observable. You will work with the GRID and the INFORMATION SHEET FOR CHILD CARE OBSERVER for this portion of the call.

Recall that the arrangement may be made for any reason. The mother does not have to be employed or in school.

There are two basic criteria that must be met in order for a child care arrangement to be observable:

(1) The child must be in care 10 hours a week or more

(2) The child must be awake for 3 hours on a typical day in care in order to make the observation feasible

You will work with the GRID to determine whether any arrangements meet these criteria (see question 32 and 33), and, if so, how many of them meet the criteria.

Once you have determined the primary arrangement, you will ask the mother a series of questions while completing the INFORMATION SHEET FOR CHILD CARE OBSERVER.

Children With One Observable Arrangement

For children with one observable arrangement, this becomes the primary arrangement. You will pick up with the script, saying "As we've told you, we'd like to see CHILD in (his/her) childcare when (he/she) is about (36) months old. We would like to visit (PROVIDER: GIVE ALL IDENTIFYING INFORMATION, E.G., WHO AND WHERE FROM GRID).

You then obtain information about the name of the provider (or of the center), address, and phone numbers.

Next, you will ask when the child started using the arrangement. THIS IS IMPORTANT FOR SCHEDULING SINCE THE CHILD MUST HAVE BEEN IN THE ARRANGEMENT FOR 2 WEEKS PRIOR TO THE FIRST OBSERVATION. It does not have to be full time for 2 weeks, just 2 calendar weeks since initial enrollment.

Then you will ask about the hours each day when the child is in the primary arrangement and fill in the actual hours on the INFORMATION SHEET FOR CHILD CARE OBSERVER.

The final step involves determining whether you can contact the provider directly and, if not, making arrangements for the mother to contact the provider and for you subsequently to recontact the mother.

For Children with Multiple Observable Arrangements

When multiple arrangements meet the two criteria for observable child care, you will need to determine which one is the primary arrangement for purposes of observation. There are five guides, which should be approached hierarchically:

(1) Use arrangements with the most hours of care per week including only those arrangements where the child is typically awake for at least 3 hours. There is one exception to this first guide. If father care is the arrangement with the most hours and there is another observable arrangement, the other arrangement will be the primary arrangement. We will observe father care only if there is no other observable arrangement.

(2) If comparable hours (plus or minus 5 hours per week), use most "formal" arrangement, in this order: group program, home-based program, non-relative, relative other than father, father.

(3) If comparable hours in same type of arrangement, use arrangement in which the child has been enrolled the longest.

(4) If all else is equal, use morning arrangement, unless the child has been enrolled in the afternoon arrangement for at least one month longer.

(5) If all else is equal, pick the primary arrangement randomly.

Once you have determined the primary arrangement, follow the procedures outlined above under Child with One Observable Arrangement.

Special Cases

There are two special cases that count as observable care and must be considered when determining the primary arrangement.

(1) The mother cares for the child at home (Question 19[1]) AND other non-sibs who live in another household are present 20 hours per week (YES to Questions 20, 21, and 23).

(2) The mother takes the child to work (Question 19[2]) AND:

    (a) She works in a child care center (Question 23[1]). (She may or may not have her child in her classroom.)

    OR

    (b) Another adult regularly spends 10 hours per week with the child as a sitter at the mother's workplace (YES to Question 25). In this case, it must be one adult spending 10 hours or more with the child. If there are two adults who each take care of the child for 5 hours per week, this is NOT an observable arrangement. If there are two adults who each take care of the child for 10 hours or more per week, select the provider based on the criteria listed for multiple arrangements (i.e., most awake hours, provider child has known the longest, morning provider, random choice).

Part 5D: INTERVIEW TO DETERMINE THE AVAILABILITY OF PEERS

During this part of the call, you will use an interview along with the Peer Grid to obtain information about the other children with whom the study child plays on a regular basis, and determine whether any of them fit the criteria for peer play. Callers should be thoroughly familiar with the criteria for peers, as well as with the format of the interview including the many Check Points and skip patterns. Flow Charts are included on Pages 44-47 of Chapter 27.2 to help you remember the various steps.

Check Point 1 - OBSERVABLE CARE: This is the starting point of the interview and by now you should know if the study child is in an observable primary child care arrangement and whether there are any other children in care. This information can be obtained from the completed Child Care Grid. Keep it available during the interview as you may need to refer to it. If the study child is in an observable child care arrangement and Question 30 on the

Child Care Grid indicated that there are other children in the arrangement you will proceed to Question 1. If not, then you will go to Check Point 2 - OTHER REGULAR CARE.

Begin by briefly describing the peer observation to the mother, so she will have a general understanding of why we are inquiring about the availability of other children. Follow the script provided on page 1 of Form 35D.

Question 1 and 6

This question allows you the opportunity to **identify the setting** that you will be inquiring about, and determine if it's okay with mother to conduct the peer observation. If, after explaining the procedure the mother says it is not possible or not ok with her to observe in observable care, go to question 6; if that is not possible either, go to question 11.

Question 2a and 2b

If the study child's primary child care arrangement is in a Family Day Care Home then use Question 2a. Ask for the names and the ages of those children and record the information on the Peer Grid in the section for the Primary Child Care to be Observed. If the study child's primary arrangement is in a center you will use Question 2b. This is because it is more likely that in center care there will be many children who are the same age as the study child and it is very unlikely that the mother will know all their names. Additionally, the names of the children that the mother does know will usually be the most familiar playmates of the study child. If there are more than 4 children list only

3 or 4 on the Peer Grid. If none of the children in the study child's primary child care arrangement are between 30 to 48 months and the same gender as the study child, you will go to Check Point 2. If the mother doesn't know the ages of the children then you will proceed to Question 5 and we will obtain that information from the child care provider.

Question 3, 8 and 13

These questions are to help you determine which peer to observe if there are several boys or girls available between the ages of 30 to 48 months.

For each child that the mother names you will need to inquire about the nature of the children's friendship, the length of time acquainted and how many hours each week they **regularly** play together. Again, keeping in mind the criteria for peers ask:

A: "How would you describe the children's friendship: Best friends, close friends, just friends, just acquaintances, or not friends?"

B: "How long have the children known each other?"

C: How many hours a week are the children usually together?"

Questions 4, 9, and 14

The peer can **not be a sibling or live in the child's household**. Other relatives, cousins for example, are allowed as long as they meet the criteria of not living in the study child's household.

Question 5

The purpose of this question is to find out if there are any other regular settings in which the study child plays with other children that may meet the criteria for peer observation. These may be another child care arrangement that we won't observe, a church based mother's day out program, a regular play group, or just an informal arrangement with a friend or neighbor. If the situation arises where it is impossible to observe peer play in the primary child care arrangement (the provider refuses, the peer's parent refuses etc.,) we will have the necessary information to determine if there is an alternate setting that may be observed and can expedite that process immediately. Record their first names and ages in months on the Peer Grid in the section for alternate arrangements, the nature of the friendship, the length of time acquainted, and how many hours each week they play together. Also ask the location where they usually play and the name of the adult in charge and record on the Peer Grid.

Check Point 2 OTHER REGULAR CARE WITH OTHER CHILDREN PRESENT

You will begin Interview 5D at Check point 2. If: (a) if the study child has a regular arrangement but will not be observed in that care or (b) Question 30 of the Child Care Grid indicated that there were no other children in the primary child care arrangement or (c) that question 2a or 2b indicated that none of those children are same sex as study child and between 30 and 48 months of age as determined in Checkpoint 1 question 2.

If the Child Care Grid indicated that there is some regular child care that we won't be observing and that there are other children in this arrangement with the study child then you would proceed with Question 6. Only describe the peer observation to the mother if you did not do so earlier.

Question 7a and 7b

Same as 2a and 2b except that this will be for other regular arrangements. If none of the children in the arrangement are the same gender as the study child and between 30 and 48 months, you will go to Check Point 3 - ALTERNATE SETTING. If the mother doesn't know the ages of the children then you will proceed to Question 10 and we will obtain that information from the child care provider.

Question 10

Same as 5 except that this will be for alternate arrangements such as play groups.

Check Point 3 ALTERNATE SETTING

You will begin Interview 5D at Check Point 3. If (a) the study child has no regular child care or (b) Question 30 of the Child Care Grid indicated that there were no other children in these arrangements or (c) question 2a, 2b, 7a or 7b indicated that none of the children are same sex as study child and between 30 and 48 months of age. Then you will proceed with Question 11.

Describe the peer observation only if you did not do so earlier. Let the mother know that this procedure can be carried out in her home or the peer's home, whatever is convenient for them.

Question 11 and 12

The purpose of these questions is to determine if there is any possibility in any alternate arrangement where we can complete the peer observation. A "no" response to either of these questions means that there will be no peer observation. Thank the mother for her help and tell her that we won't be able to do that part of the visit. Go on to part 6 of the 35-month phone call and schedule the home and playroom visit. If there may be potential peers at an alternate setting but the mother does not know the ages of the children then go to Question 4, Part 5E.

SELECTION OF PEER

Use the Peer Criteria and the information from the mother that you have recorded on the Peer Grid to select two possible peers. If there are suitable peers then you proceed to Question 1 of Part 5E of the 35-month phone call and complete the Peer Information Worksheet for each peer. If there are no suitable peers for the observation in any setting then you'll need to tell the mother that we won't be able to do that part of the visit and provide an acceptable reason why. At this point some mothers may try to help by telling you the name of someone that the study child plays with or that she knows of a child who could come to play with the study child. Unless these children meet the criteria for peers, including the criterion of having known each other for at least 2 weeks, you must thank the mother and restate that we won't be able to do that part of the visit. Go on to part 6 of the 35-month phone call and schedule the home and playroom visit. If there may be potential peers but the mother has been unable to provide any key information necessary to identify peers then go to Question 4, of Part 5E. This information will be obtained from the child care provider at the end of the first visit or from the adult in charge of the alternate setting.

THE CRITERIA FOR PEERS:

a. In age range from 30 to 48 months

b. Same gender as study child.

c. Has been acquainted with STUDY CHILD for 2+ weeks (preference given to children in the child care setting that we will be observing for the 36 month visit); it is not preferable to observe the study child's "best" friend or a child not familiar to the study child.

d. Is not a sibling; does not live in same house as STUDY CHILD

e. Is not a subject in NICHD study unless no other peer is available.

Part 5E: COMPLETING THE PEER INFORMATION WORKSHEET

You will have obtained the first names of two peers during the interview process. For the first- and second-choice peers of those available you will need to obtain additional information so their parents can be contacted for their consent for the observation. Begin Part 5E: with Question 1, if a peer has been identified, or with Question 4, if the mother has been unable to provide any key information necessary to determine if the peer meets the criteria. Because of the wide range of situations likely to be encountered, it is important to be very familiar with the interview, as well as the suggestions in the Problem Solving section of the Peer Manual. The contact information should be obtained from the mother if at all possible. If the mother cannot provide contact information, first contact will be made through the child care provider or the adult in charge of the alternate arrangement. For more information on this process see Part III: ARRANGING PEER OBSERVATIONS in the Peer Manual.

You will use the Peer Information Worksheet to record all contact information the mother can give you about the peers. This worksheet will also be used to track the steps necessary in order to obtain consent for observation and will be retained at each site. In cases where peers' parents do not have telephones or they are unable to be reached after several attempts, a Parent Permission Packet (Appendix F of Peer Manual) can be sent out directly without the phone contact. In all cases, if the signed consent is not returned within a week, a follow-up call to the peer's parent must be made. If the peers' parents do not have telephones and the consent is not received within a week, begin the procedures for enlisting help from the child care provider (see Part III of Peer Manual).

More complete information regarding obtaining information about and contacting peers' parents is included in the Peer Manual.

If no peer is identified or permission to do the observation is refused, complete a Missing Peer Data Report Form (DM-M) and send it to the DCC as well as to the Kansas Site to document the missing data.

PART 6 and 7: SCHEDULE HOME AND LAB VISITS

This is a very important part of the procedures for the 36-month assessment. The home and lab visits may be scheduled at the conclusion of the 35-month calls, as planned. However, they may also be made in separate calls. In this latter case, it is important to use the language in the following scripts when describing the content of the various home and lab visits. The scheduler needs to describe briefly both visits and set up the dates and times for these visits (see windows and ideal times, below.)

WINDOWS FOR HOME, LAB AND CHILD CARE VISITS

	IDEAL	WINDOW	EXCEPTION PERIOD
36 Month Lab Visit	The Week after the Home Visit	36 Months, 0 Days to less than 38 Months, 0 Days	38 Months, 0 Days to less than 41 Months, 0 Days
36 Month Home Visit	36 Months	36 Months, 0 Days to less than 38 Months, 0 Days	38 Months, 0 Days to less than 41 Months, 0 Days
36 Month Child C. Visit	The Week after the Home Visit	36 Months, 0 Days to less than 38 Months, 0 Days	38 Months, 0 Days to less than 41 Months, 0 Days

RULES OF THUMB FOR SCHEDULING THE VISITS:

1. The home visit should precede the lab visit, unless this is logistically impossible (e.g., cancellations). This is very important and you should change this order only if you risk losing a visit.

2. The 36-month lab visit should be conducted as close to 36 months as possible.

3. The child must be awake, alert, and healthy for the lab visit. The visit can be scheduled for any time of the day that the mother says will be a time that child is usually alert and awake.

4. At 36 months, the child must be awake and alert for at least part of the home visit. In general, allowing time for greeting the mother, taping or observing the mother, interviewing the mother, and giving the mother information for the lab visit, the visitor will be in the home for about 2 hours. That amount of time should be scheduled with the mother.

After the phone call, a confirmation letter should be sent (see Appendix A). This letter should include the dates and times of the visits.

Please use the following descriptions of the home and lab visits when scheduling these visits. They are slightly revised from what is on the scantron forms.

SCRIPTS FOR THE HOME AND LAB VISITS AT 36 MONTHS

Now the last thing I need to do is schedule our visit to your home and your visit to our playroom when CHILD is 36 months old. You may remember that at 36 months, we will need to see you in your home and also at our children's playroom at [SITE LOCATION]. I would like to ask you a few questions and tell you a little bit about these visits. (Ask 3 questions on page 1 and code answers.)

HOME VISIT

The home visit will take about 2 1/2 hours and will be similar to the 15-Month Visit. We will talk with you about the things you do with CHILD and we will ask you some of the same questions we asked in earlier interviews. We'll ask you to fill out some questionnaires and we will also administer a brief screening measure.

Now we would like to set up the visit to our playroom.

LAB VISIT

The playroom visit will take about 2 1/2 hours. During this time, we will videotape CHILD playing with toys; we will do some measures of language and play styles, and we'll videotape you and CHILD playing together. We'll ask you to fill out some questionnaires and to answer some questions.

If mothers ask if they will have to leave their children as they did at the 15 month visit, you may say: "Yes, we will have a Comings and Goings activity similar to what we did at 15 months. There will be two separations a few minutes long that will end immediately if CHILD gets distressed. You will be in the observation room while apart from CHILD and can return at any time."

It is important however, to communicate that the mother should not coach the child ahead of time about the details of what is going to happening the playroom. Tailor the following response to the mother's particular concern.

"There are several reasons why you and CHILD are in separate rooms for part of the visit. We are interested in variations in the early development of self-reliance, so for some of this time we want to see how CHILD behaves when you are nearby but not in the same room. Because self-reliance is one of the areas in which we are interested, we ask you not to tell CHILD ahead of time that you and child will be separated for part of the playroom visit. We prefer that you simply explain that you and CHILD will be going to the playroom at (SITE), as you did when CHILD was younger, and that there will be lots of different things to see and do there."

Each site may know one or two mothers who were upset at the 15 month Strange Situation. If, in their judgement, it would be a good idea to let these mothers know that we are doing "Comings and Goings" again at age 3, then use the following script in the phone call:

> "At 36 months we will be doing the "Coming and Goings" procedure again. This is an important measure of differences in early self reliance. We know that you expressed concern about being separated form your child at the 15 month playroom visit and we wanted to let you know that Comings and Goings this time is similar but shorter. Do you have any questions or concerns that you would like to discuss ahead of time?"

If the mother wishes to discuss concerns, please let her know that you will have someone (probably the VC or PC) call her to discuss her questions and concerns, if she so wishes. Try to avoid asking her permission to conduct the procedure. Rather, we want the VC or PC to explain the procedure so that she is comfortable with it.

XVIII. DEBRIEFING

Follow the script as written, being sure to give the mother a chance to ask any questions she may have. It is a good idea to make a note of any questions and what your response is, and to check with your site coordinator and/or P.I. to be sure all staff members are following the same procedures. If you are at all unsure about the answer to a question, do not try to answer it. Instead, tell the mother you will find out and call her back.

Talk to the site coordinator and/or P.I. and arrange for someone to call the mother back within that same day if possible.

Conclude the interview by telling the mother when she will be contacted next and what will happen at that contact.

XVIV. APPENDICES

A. 36-month Materials

A1. Sample Letter to Send to Mother When Unable to Contact by Phone

Mother's Name
Last Known Address

Dear _________:

Thank you for agreeing to participate in the NICHD Study of Early Child Care. We have enjoyed getting to know you and BABY, and it's good to have you as part of the study.

We have been trying to contact you to find out how you and BABY are getting along. Please fill out and return the enclosed card to us, or call our offices at AREA CODE/PHONE. Feel free to call us collect. Also, you can call at any time and leave a message on our answering machine. Please let us know the best way to contact you.

We hope things are going well for you and BABY. We look forward to hearing from you soon.

Sincerely,

Project Staff Member

Enclosure: Return postcard

A2. Materials to Send to Mothers Who Let You Contact the Provider

LETTER DESCRIBING 36-MONTH CHILD CARE VISIT FOR MOTHER

Mother's Name
Last known address

Dear :

As we discussed on the phone, we will be contacting (NAME OF CARE PROVIDER) about our visit to observe CHILD [or when CHILD is at the day care center].

We want to find out what CHILD is usually like when (she/he) is in (his/her) care [or at the center], and also a little about the people caring for (him/her). To do this, someone from our staff will visit BABY's child care to watch for about three hours on two different occasions. This person will also talk to the care provider about (his/her) education and experiences in caring for children and about how your child spends the day. The care provider will also be asked to complete several brief questionnaires about your child, similar to those you have completed, and about (his/her) feelings about providing child care. At the end of the visit, we may videotape CHILD and a friend playing with some toys that we will bring for approximately 15 minutes.

(His/Her/Their) participation in the study will be of great value. It will provide important information to help us learn more about those things that lead to healthy development for young children.

Thank you for your help.

Sincerely,

Project Staff Member

A3. Materials to Send to Mothers Who Want to Make First Contact With Child Care Provider

1. Letter describing 36-month child care visit for mother

Mother's Name
Last known address

Dear :

As we discussed on the phone, we would like you to talk to (NAME OF CARE PROVIDER) about our visiting when (she/he) is caring for CHILD [or when CHILD is at the day care center]. We have enclosed a list of points that you should be sure to mention when you talk to your provider.

We want to find out what CHILD is usually like when (she/he) is in (his/her) care [or at the center], and also a little about the people caring for (him/her). This would mean someone from our staff coming to watch for about three hours on two different occasions. This person would also talk to the care provider about (his/her) education and experiences in caring for children and about how your child spends the day. The care provider would also complete several brief questionnaires about your child, similar to those you have completed, and about (his/her) feelings about providing child care. At the end of the visit, we may videotape CHILD and a friend playing with some toys that we will bring for approximately 15 minutes.

The care provider may be a little uncertain about the visits and want to know more about them. We have enclosed some information that you can give (him/her). Specifically, feel free to mail or give the enclosed letter from us, along with the study description, to your care provider. You can also tell (him/her) that we will be phoning to talk about the visits in more detail and to answer any questions.

(His/Her/Their) participation in the study will be of great value. It will provide important information to help us learn more about those things that lead to healthy development for young children.

Thank you for your help.

Sincerely,

Project Staff Member

Enc: Letter to Care Provider
     Study Description for Care Provider
     List of points to mention to the provider

BE SURE TO MENTION TO YOUR PROVIDER that...

1. You have given your permission for your child to be visited at child care.

2. You have been in the study since your child's birth and (we sincerely hope) have enjoyed the experience.

3. All information that is gathered on the child and the child's child care is kept strictly confidential. This information we gather during our visits will only be shared with project staff. No one will be named in any reports of the study. All information is kept in locked files at the site.

4. We need the provider's permission, in addition to yours, to visit the child at child care.

5. Someone from the study at the site will be calling them in the next few days to describe the child care visit in detail and to answer any questions.

6. We will pay the provider $40 for his/her participation.

7. You hope she/he/they will participate.

A4. Letter for mother to send to her provider

Dear ____(NAME OF PROVIDER)____,

As you may already know, ____(MOTHER)____, and her child, ____(CHILD)____ are taking part in an exciting and important study called the NICHD Study of Early Child Care. They have been in the study since the CHILD was born.

The major aim of the study is to learn how the different people, places, and events in the lives of young children affect their development. We have attached a one-page description of the study for you to read and even to post if you would like.

As part of the study, we need to see ____(CHILD)____ in his/her child care setting since this is such an important part of his/her early life. We would like to come and ____(CHILD)____, when she/he is with you. ____(MOTHER)____ has given us their permission to do this. We will pay you $40 for your participation.

We know you are busy, and we will arrange our visits at times convenient to you. We will also respect the routines and responsibilities of the caregiver(s) during our visits. We want to see what the child is usually like when she/he is with you. We would just watch whatever the child typically does and ask some questions about how she/he usually spends the day. We would also ask you some questions about your own education, child care experiences, and feelings about providing child care.

Your participation in the study will provide valuable information which will help all of us learn more about young children's development. All of this information will be kept strictly confidential. We will be calling you to tell you more and to answer any questions that you may have about the study.

Sincerely,

Project Coordinator

Enc: Study Description

A5. Description of study

THE NATIONAL INSTITUTE OF CHILD HEALTH AND DEVELOPMENT

STUDY OF EARLY CHILD CARE

Children born today will be growing up in a world different from that of their parents. How will growing up in the 1990's affect children's development? To answer this most important question for America's future, the National Institute of Child Health and Human Development has funded the NICHD Study of Early Child Care.

The NICHD Study of Early Child Care is being conducted at ten different sites in the United States. The main aim of the study is to learn about the variety of people, places, and events that children experience in their early years and the many pathways that lead to healthy development. Aspects of development that will be studied include social, language, cognitive, and health outcomes.

Families become involved in the study on a voluntary basis soon after the infant's birth. Several times during the three years that the families are involved in the study, the children, their parents, and other caregivers will be observed and interviewed. Parents are asked to describe their views about childrearing, their feelings about working and parenting, and their perceptions of the child's personality and behavior. Because child care outside the family is also an extremely important setting in which children grow and change, caregivers are asked to participate as well. Summary results will be available to all study participants at the conclusion of the project in 1995.

VISITS TO CHILD CARE SETTINGS

Each child is the study is visited in his or her care setting on two different days, when he or she is 6, 15, 24, and 36 months of age.

At the first visit, a staff member observes the child for about 3-4 hours. She tries not to interfere with the usual routine in the child's room. At the end of the visit, she leaves 4 questionnaires for the child's caregiver(s) to fill out before the second visit. These questionnaires contain questions about the caregiver's education and experience. This should take no more than 20 minutes of the caregiver's time, and the staff members work around the schedule and routines of the caregiver(s).

At the second visit, the staff member again observes the child for about 3-4 hours. Then, she talks to the caregiver(s) briefly about the child's activities and about the caregiver's education and experience. Again this should takes no more than 20 minutes of the caregiver's time, and the staff member will be considerate of the caregiver routines and responsibilities. If possible, she videotapes the child playing with a friend for 15 minutes sometime during the session.

Because we want to see what usually happens when children are in child care, we try to make our visit interfere as little as possible with the caregiver's routine.

The results of this study will not only guide policy makers, but will also be of more immediate use to parents and child care providers as they engage in the rewarding, but challenging, responsibility of rearing young children.

A6. Sample Appointment Letter for 36-Month Home Visits

Date

Name
Last known address

Dear :

This letter is to confirm the appointment that we made. I will be visiting with you at your home on (day of week, month, date, time).

We would like you to bring CHILD to our playroom at the University on (day of week, month, date, time). We will give you directions to the playroom and a parking permit before your visit.

Please feel free to contact me at (608) 263-1565 or 263-1662 if you have any questions or concerns. I look forward to visiting with you.

Sincerely,

NAME
NICHD Study of Early Child Care

ADDENDUM TO CHAPTER 26
OVERVIEW OF THE 36 MONTH VISITS
HOME, LAB, AND CHILD CARE

Information Regarding the Family Tapes

For several months the Virginia office staff, undergraduates and graduate research assistants have been placing home and lab visit segments onto a tape for families. However, when the Virginia site went back and tried to place the header and ending segments created at the Seattle site onto their tapes, they realized that there was no room on their tapes, and they therefore had to recopy the tapes.

As the Virginia site worked on recopying the tapes, they noticed that many times the segments included the rear views of RAs setting up or breaking down the home visit mother-child interaction segments. Those portions were edited so that the tape only included segments of the mother and child together.

The Virginia site has also taken the time to edit segments which include any disruptive behavior by the child or obvious embarrassment on the part of the mother. Segments that have problem behavior throughout have been being substituted entirely.

Other situations in which editing was necessary involved cases during Solitary Play where conversations between the mother and VC could be heard in the background. For instance, one mother was heard discussing the fact that she was about to start taking Prozac which would cause side effects such as diarrhea, violent behavior, etc. The staff at Virginia felt that a much more pleasant segment could replace this particular segment so that such personal information would not be revealed to family and friends viewing the tape. The Virginia site will continue to watch for other cases in which conversations might include other personal information such as marital problems, the child's condition, financial troubles, etc.

Another concern expressed about the Solitary Play segments was that in some extreme cases, some mothers may appear distant towards their child, when in fact they have been instructed to discourage interaction with their child.

One suggestion that the Virginia lab team proposed was to include Snack on the tapes, since it seems to be the time when the mother and child are most relaxed and comfortable.

All sites are encouraged to alert the Virginia site of other situations that might detract or add to the intent of such gift tapes.

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CHAPTER 26

OVERVIEW OF 36-MONTH VISITS: HOME, LAB, CHILD CARE

I. DATA TO BE COLLECTED 1

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- B. Lab Visit 2
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IV. RULES FOR OVERLAP OF STAFF 4

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CHAPTER 26

OVERVIEW OF 36-MONTH VISITS: HOME, LAB, CHILD CARE

I. DATA TO BE COLLECTED

When the child is 36 months old, the following data are collected.

A. Home Visit

1. Bracken Scale of Basic Concepts (administered to child)
2. H.O.M.E. (Preschool Version)
3. Standardized Interview
4. Questionnaires
    - A. My Feelings (15D)
    - B. Parenting Experiences (15I)
    - C. Relationships with Other People (15F)
    - D. Family Finances (15H)
    - E. Love and Relationships Part I (3I)
    - F. Combining Work and Family (15G)
    - G. What Employment Means to Me Part A or B (3D or 3E)

B. Lab Visit

1. Solitary Play
2. Clean-up (Compliance)
3. Separation and Reunion
4. Snack
5. Reynell Developmental Language Scale (administered to child)
6. Child Behavior Checklist
7. Self-Control with attractive toy
8. Adaptive Social Behavior Inventory
9. Three Boxes Mother-Child Interaction
10. Peabody Picture Vocabulary Test - Revised (administered to mother)
11. Television Viewing Interview
12. Growth Measures
13. Growth Compliance

C. Child Care Visits (2)

1. ORCE Behavioral and Qualitative Ratings - 4 cycles
2. Dyadic Peer Interaction
3. Profile
4. H.O.M.E. (Family Day Care and Nanny Care only)
5. Caregiver Interview
6. Caregiver Questionnaires

II. SCHEDULING VISITS

The age window for the 36-month visit is 36 months 0 days to less than 38 months 0 days.

The exception period is 38 months 0 days to less than 41 months 0 days.

A. Begin phone calls to schedule visits at 34 1/2 months.

B. Visits should be scheduled early in the window initially in order to allow for delays and rescheduling.

C. Normally the home visit will precede the lab visit, but the order is not essential. Do not cancel a lab visit if a home visit is delayed.

D. If the child's care arrangement is in her/his own home, do the home visit to the mother before the child care observation. For other child care settings, the order of home and child care visits is not important.

III. DATA COLLECTED DURING THE EXCEPTION PERIOD

All data collected during the exception period (38 months, 0 day to 41 months, 0 day) must be sent to DCC along with an Exception Period Data Collection Approval Form (See Appendix of Chapter 14). This form informs the Principal Investigator at the site that data were collected during the exception period. For this reason, the form must be signed by the Principal Investigator.

The form should be sent along with the data that were collected during the exception period, with the form at the top of the pile of data and underneath the transmittal form. Also indicate on the transmittal form that the form is being included in the shipment .

IV. RULES FOR OVERLAP OF STAFF

A. At 36-months, the same person may not do the home and child care visits for the same family.

B. The home visitors for a particular family may conduct the lab visit.

C. The same person may not do both a child care and a lab visit for the same family.

D. Sites will make reasonable effort to maintain the blindness of observers, as described in the 36 month Home manual. Sites will try to design staffing plans such that 35 month callers are not also collecting data at the 36 month assessment.

V. THANK YOU NOTE

After a family's home and lab visits have been completed, sites should send a thank you note to the family.

ADDENDUM TO CHAPTER 27.1
ADMINISTRATION OF THE 36 MONTH CHILD CARE VISIT

I. Interviews and Questionnaires

A. Which Interviews To Give and When

It has become apparent that different sites have been giving different interviews in the same circumstances since at least the 15 month assessment. This has come to light with the change to a two column interview for the mother/director telephone interviews at 36 months and because the instructions for center and family daycare situations are unintentionally different. It has been decided that at 36 months a more detailed and hierarchical set of directions is warranted. This is based upon the availability and willingness of the caregiver/director to participate.

SOLUTION:

1. In the following 3 instances give the Mother Telephone Interview for Arrangements We Cannot Visit (36-B and 36-C):
   a. 35-month phone call: Mom says we may not contact the CG at all.
   b. 35-month call: Mom says she will contact the CG first. She does and the CG doesn't want to be contacted.
   c. 35-month call: Mom says it is OK for us to contact the CG or director. We do and the CG/Dir refuses the visits AND to speak further.
2. In the following 2 instances give the appropriate CG or DIR interviews AND FILE A MISSING DATA FORM FOR ALL THE OBSERVATIONAL MEASURES when you send in the interview. (ORCE, Post Visit Interviews, H.O.M.E, etc.)
   a. 35-month call: Mom says OK for us to contact CG. CG refuses to allow the visits, but is happy to do a phone interview.
   b. 35-month call: Mom says OK for us to contact the center. Director says center policy forbids any observational data collection, but that the director is interested in the study and would be

happy to answer questions over the phone or even in person. Give the Director Telephone Interview (11-A) and see if s/he will also complete the 11-D or 11-U questionnaire and the 11T Center Director-Background Information questionnaire. You should also try to see if the SC's caregiver might be willing to do just the long or short caregiver interview for centers as well.

RATIONALE:

1. Data "straight from the horse's mouth" is better than secondhand data. That is, the director or caregiver is a much better reporter of what is happening at the care setting or of their own background than the mother.
2. Both Mother/Director Telephone Interviews for Arrangements We Cannot Visit contain far less information than the interviews intended to be given to the directors and caregivers in person.
3. If you have a willing director or caregiver on the line they don't know they are being given a more complete interview. We get more data, and they are willing and feeling that they are contributing something even if they cannot consent to an actual visit. One site also always gives the mother The Mother Telephone Interview as well so that the overall reliability of these shorter interviews can be checked with the caregiver interviews. This site then sends in the caregiver interviews as real data along with the missing forms report.

B. When To Use the Long and Short Caregiver Interviews

A clarification as to when to use the long and short caregiver interviews at the 36-month assessments has been requested.

The rules governing when to give the long and complete battery of director interviews and questionnaires has changed (as of December 1993) so that at least once every assessment period sites should have the information from a long interview and questionnaire battery. This was done to avoid a potential situation where important information dealing with profit/non-profit status, credentialing, and staffing changes might be missed if sites could string along enough kids in one center to never do another full battery because of the 4-month rule. The caregiver interviews were only slightly modified because there was hardly any crucial information in the long form that could change that wasn't addressed in the short form. Thus, the caregivers age, race, and English as a second language status wouldn't change no matter how long it had been since we saw them, but their affiliation with nanny groups or their level of education could change. We wanted to avoid, however, instances where sites last saw the CG at the SC's 6-month or 15 month visit and not again until 36 months. Therefore, it was decided that a long form of the appropriate caregiver interview must be given to all new CGs and to any CG not assessed during the 24-month assessment period, whether they were seen at 6 or 15 months or not. It was also decided to give a short CG interview if the CG was seen during the 24-month assessment time or previously during the 36-month assessment period.

C. Center Director Background Information

For cases in which RAs found the center director to be unhappy about doing the 11T over again, a shorter version of the 11T has been developed. The shorter version is Form 36W. Please note that this form does not take the place of Form 11T - it is only to be used with directors who have already completed the long version (Form 11T) in the past.

D. Child Caregiver Interview (Long Version) - Form 11J

1. For question J6 the manual (Chap. 27.1 pg 87) currently says to "code no if had license and no change, code yes if license renewed." - but how do you indicate that a license may have been lost?

CODE "NO"

2. Questions D28, E5, F5, G14, and H5 ask where the careprovider's children are when NOT AT HOME during the day. There have been several careproviders who either have their young children in their family day-care, or have their school-aged children home for the summer when the visits were conducted. In these cases, the careprovider's children were AT HOME during the day so these questions (D28, E5, F5, G14, and H5) could not be answered and thus, they were left blank. How should this issue be addressed? Should these questions be answered as OTHER and then write in HOME?

Yes, answer as OTHER and then write in home.

E. Director Change Form (Form DM-J)

If a child is in a center that has been visited before and, at that the time, the director filled out the director background and questionnaire forms, but the center now has a new director, please do the following:

- * Fill in the Director Change Form listing the original director/arrangement ID, but do not indicate who the new director is or give a new ID#
- * The arrangement ID remains the same as before for the center
- * The new director fills out the Director Background Information (11T) and the Director Questionnaire - For Centers Visited Before (11U).
- * Do not need to send in a data edit with DM-J form

F. Questionnaires Returned After the Window Closes

If a child care visit is completed within the window, but the care provider returns his/her questionnaire packet to the site after the window for that child care assessment has closed, please send the questionnaires to the DCC along with a DM-G form.

G. Non-English Observation in Child Care - Form 36N

Form 36N should be completed after EACH child care visit for the same child (twice per child). However, only one form needs to be filled out per child care visit. Therefore if the child hears more than one non-English language, just check both languages on the form and add the amounts of time for the estimate of "How often...". It may be helpful to think of the question as "How often did the child hear language other than English addressed to him/her by the caregivers?" rather than "How often did caregiver(s) speak to the child ...".

II. Co-Operative Preschools

Please note that co-operative preschools, as well as regular pre-school programs may be coded as child care arrangements started or stopped by mother. Parent co-ops and regular preschools should be coded as centers, and if the mother volunteers/works there, then the child is considered to be in care with the mom. As for number of adults supervising the children, code the number of adults present at any one time (vs. total number of adults that the child comes in contact with).

If you are one of the sites that has mother co-op centers, please schedule your child care visits on days when the mother is not present or not in charge of her own child, if at all possible.

III. Interrupted Center Care

The Kansas child care team did a first visit on a study child in center care. Before the second visit could be done however, the child's care provider left permanently. There were a series of substitutes being used at the time. Their question was whether to do the second visit at that time, or to wait until the child had a new regular caregiver and then do the second visit, or to wait until the child had the new regular caregiver and then do two new visits.

SOLUTION:

1. Wait until the child has been in care for at least two weeks with the new caregiver and do TWO visits.

2. No new 35-month call is needed. If the mother has given you the first name of the particular caregiver, just pencil in the 1st name of the new caregiver on the grid and the written portion of the phone call for your own information. Since My Child Care is no longer done in the home visit, that is no longer a consideration.

3. You will need to do a new Director Telephone Interview, (11A) because questions 3-5 ask for the individual caregiver's name etc., how many paid child care staff have left the program and joined the child's group since the child was enrolled. Obviously this information has changed.

4. If you have done the fist visit and used the 11D Director Questionnaire (Long Form), then update Section C which deals with staff turnover. If you have done Form 11U Director Questionnaire for Centers We Have Visited Before (Short Form), transcribe the few answers to the questions on that form to the identical ones on the long form, 11D, and administer the rest of the questionnaire with an explanation to the director of why this is now necessary.

5. Destroy ALL forms from the original visit. Send to the DCC only the new forms from the two new visits and the corrected or updated director forms.

RATIONALE:

The child care visit is intended to examine the setting and the relationship between the study child and his or her regular caregiver. Stability of center staff will be captured through the director interviews, the caregiver interview, and the 35-month phone call. There is NO mechanism within the existing system to register staff changes with the ORCE. There is no way to know that the visit was not just a mistake on the part of the child care observer versus a permanent staff change, etc.

IV. Unique Child Care Situations

1. A Montessori School in the teacher's home - the teacher has indicated that she is a licensed as a center. The school is in the basement of her home and the children do not use the residential part of the home.

This situation should be coded as CENTER CARE. The deciding factor is that the arrangement is officially licensed as a center. If there were no center license, it would be a family home care arrangement.

2. Music lessons, swimming lessons, gymnastics, etc ARE NOT considered child care arrangements.

3. Joint custody - for Phase I, the time the study child spends with the father in joint (shared) custody is not considered child care. If the father cares for the child beyond his normal custody arrangement, those hours can be considered child care.

4. Child care arrangements used by the father when child is in his custody. For Phase I we use only the information about child care arrangements as described by the mother. We have not asked fathers about child care arrangements. Therefore, if the mother does not know what arrangements the father uses, we would NOT CALL the father for the information. This may change for Phase II.

5. Mom enrolled in a residential treatment program - The mom and child are in the residential treatment program 24 hours a day. However, the child is in a nursery part of the time without his mother, with his mother in the nursery part of the time, and the child stays with his grandmother in her home overnight a day and a half each week.

This situation has 3 separate child care arrangements. The nursery in the treatment program should be observed when the mother is not caring for the child, as this is the most formal of the arrangements.

6. Father has legal custody of the study child, the father was interviewed and the child care arrangement he used was observed at 15 & 24 months. At 36 months, the mother has visitation rights but the child is in the care of the father the majority of the time.

The 36 month visits and interviews should CONTINUE WITH THE FATHER. The child care arrangement used by the father should continue to be observed at 36 months.

This may be modified for the Phase II study but for Phase I we will be consistent with the decision rules used up to this point.

7. If there is a situation in which the study child is in care more than ten hours a day on a regular weekly basis, and the child is awake for at least 3 hours of that time, then the fact that it takes place all on the same day does not matter. It is an observable care arrangement. At three years of age, that child knows that on that particular weekday each week, s/he will be in non-maternal care for all day.

However, nine hours of child care in 1 day does not qualify as observable child care. The 10 hour criterion is still used at 36 months.

8. One site has a mother child care provider whose husband is off from work at least 1 day a week for about six hours while she is doing child care. Her husband was home when they observed. He interacted with the kids throughout their observation. Their questions were:

- Does he get assigned a regular or dummy child care ID number;
- Is he counted on form 36X (Mother-Provider Caregiver Interview) question B9 as a helper, and if so, how is he coded on question B10? The mother did say that he helps on a regular basis when he is home and she is caring for other children.

Since the father is with the study child no more than 6 hours a week regularly during child care "business" hours, he gets a dummy child care ID because he does not pass the 10 hours/week criterion. (This also allows him to be rated on the Qualitatives, if he meets the other criteria for coding.) He is then counted as a regular helper on question B9. Since there is no "spouse" choice under question B10 on this form, code the father as (1) - A relative. Response code (2) "Another parent" suggests the parent of another one of the children in care, such as a co-op arrangement, as opposed to the "other" parent or father of the child.

9. What if the SC is in a center arrangement and the director is also the SC's regular caregiver. Which interviews and questionnaires should the director/caregiver complete?

The answer is all of the director and caregiver measures. They should be thought of as two separate persons. There is different material gathered in the Director Phone Interview, Background Questionnaire, Director Interview, Caregiver Questionnaires, and Caregiver Interview. Think in terms of data analyses and missing data forms. This person will just have to have the tasks presented as separate pieces of the puzzle, or role- rather than person-related.

10. A center observed at 24 months has been sold. The name of the center has been changed, as were the director and some of the teachers. The question is: Should a new Center ID number be assigned?

DO NOT ASSIGN a new center ID to this situation. The changes are transparent to the child and family. If there are changes due to the change in management, they will be reflected in a Director Change Form, possibly a change in caregiver IDs for the child, and possibly changes noted in the Profile.

V. ORCE

A. Behavioral Questions

1. Should positive/neutral behavior be coded when study child tries to interact with an infant?

Yes, positive/neutral behavior may be coded if the SC gives any special overture, it doesn't matter if the infant responds or not.

2. If a child yells "No, get away from me, you butthead!" and pushes a child at the same time - should this be coded as a negative act, verbal aggression, physical aggression, or all three. What if this act is directed towards an adult- would it be act defiant?

Code this as verbal aggression AND physical aggression. If it is said to an adult, code it as verbal and physical aggression when the SC initiates the behavior, but, if the adult was trying to control or direct the SC and s/he responded in this manner, code the child's behavior as acts defiant.

3. If a caregiver says, "Can you show me?" while s/he and the SC are talking about an activity such as ballet, and the child complies, would this be asks question or gives direction? For example, the caregiver and child are looking at a book and the caregiver asks, "Can you show me a giraffe?"

These are gives directions (because the child complied).

4. In order to code complies, must there always be GIVES DIRECTION? For example, can complies ever be coded with asks question?

There must always be a gives direction before you code complies. Here is a good rule to use. A direction requires an action. A question requires only an answer. So one can't code comply to a question, comply may only be coded with a direction.

5. Is "mine and no" always coded as a negative act, even if it is not directed at someone?

A negative act has to be directed to SOMEONE. Negative action means negative towards someone - not negative mood.

B. Prosocial Behavioral Questions

Responses to questions on prosocial behaviors:

1. Sharing Food - This is not prosocial if the kids are eating snack at a table and the SC is passing food around, this is positive interaction; but, if the SC is across the room and goes over to another child and gives him/her a cracker, then this would be prosocial behavior. The SC needs to initiate a friendly gesture (think of the training tape at the Montessori school); if another child is showing distress and the SC gives him/her comfort by presenting food, then this is also prosocial behavior.

2. Helps With Toy - This is not prosocial in the context of play and the other child is not having trouble with the toy and the SC is just showing how the toy works - this would be positive interaction. However, if the other child is having trouble and needs help with the toy, and the SC goes over to help the other child, then this would be prosocial behavior. Another example of prosocial behavior would be if the SC sees the other child in distress while this other child is playing with the toy, and the SC says, "Here, let me help you with that toy, this is how it works."

3. **SC Asks if S/He Can Help** - No; in this case the SC is seeking interaction with the other child, trying to get his/her attention and since the other child didn't ask for help, then this would be more of a positive interaction on the SC's behalf. However, if the other child was struggling with the toy and needed help, and the SC initiated the help, then this would be prosocial. It has to be clear that the SC is being kind or nice rather than trying to find a way to entertain him/herself.

4. **Good Manners** - No

5. **Carrying a Chair** - Yes, this would be prosocial because the SC is being helpful and cooperating with the other child and the SC comments on it.

6. **Saying Something Complimentary** - Yes, but please keep in mind that it has to be clearly initiated by the SC, s/he should not be modelling an adult.

7. **Telling They are Good or Good at Something** - Yes

8. **Saying Thank-you** - No

9. **Snuggles with Caregiver** - Yes, if this behavior is initiated by SC and the SC is being warm, affectionate, and loving.

10. **Any Cooperative Play** - No, it has to be a high level of play with lots of fun, laughing and giggling that is carried on for longer than a quick interaction (and if you want to, think about an interaction longer than 5 seconds as a guide). If the children are just taking turns, one does it, then the other one does it, or if the SC said "It's my turn now, you go after me", then this would not be prosocial behavior. However, if the SC says, "Why don't you go first before me" and they are going down a slide, then this would be prosocial behavior.

A good guide to follow would be to consider if the SC is thinking of the other person rather than him/herself. Is the SC sympathetic, empathetic, or kind to the other person? Prosocial can be playing a game with other children if the kids are really involved and having fun, laughing, etc.

All cooperative play should not be included however, it is important to separate the high level, enthusiastic behavior between two people from just play, which would be more positive interaction.

C. Dummy Caregiver ID Numbers

The system used to assign dummy caregiver ID numbers to caregivers who are observed during the ORCE cycles has been standardized. In order to do a cross check of ID numbers the first digit of the caregiver ID needs to be the site number. The unused digits will be 9s. For example, if Arkansas had only one dummy caregiver ID to assign it, would be 0999999; if two dummy caregiver IDs needed to be assigned, then one would be 0999991 and the other would be 0999992.

This will done for the 24 month data as soon as IDs are verified that they are in fact dummy caregiver IDs. In the edits received for the 24 month ORCE data, the edit message will state that the first digit of the caregiver's ID needs to be the site number. Please verify that the ID number in question is a dummy ID, the DCC will then standardize the caregiver IDs as explained above.

This was also done for the 15 month data, however there is no need for sites to go back and re-do any numbers. However, please make sure that members of your site implement this system for the remaining 36 month data.

VI. Family Profile

A. Item Clarifications on the Profile (Center Version)

1. Learning Environment: Item A.1 - Can Fisher Price people or Barbies be counted as drama or as manipulatives? Does this depend on how it's used?

Fisher Price people and Barbies should be counted based on how they are primarily used, but count them only in one category (i.e., either as manipulatives or dramas).

2. Learning Environment: Item A.3 - do crayons and markers count?

Crayons and markers may only count as an art material if it has not already been counted as language materials (Item A.7).

3. Learning Environment: Item A.9 - Is this an exception to the accessibility rule? Do the observers have to see the child look at a poster or play with a toy (i.e. grass skirt, multi-cultural doll)?

Accessibility still applies to this item, the child must have physical access as well as permission to use. In terms of a poster or pictures, they are considered to be accessible if they are displayed at the child's eye level (i.e., no higher than an average adult shoulder height).

4. Safety and Health: Item A.4 - How does a First Aid kit fit into this item? What about written evacuation rules?

This item does not include reference to a First Aid kit, nor does this item ask the observer to assess the quality or content of written evacuation.

5. Safety and Health: Items B.1 & B.2 - What if lunch time happens after the first 15 minutes- can observers go back and change the rating? What if the observers never see a snack or lunch time?

Score the Profile as circumstances provide information. General guidelines were provided because it is generally easier to begin with physical characteristics than interactions, however, items or sections do not need to be in a specific order. If no meal or snack is observed, score based on hand washing and toileting practices.

6. Safety and Health: Item B.4 - If the observers don't see any soiled clothes, then "--OR--soiled clothes are not evident," applies and score the item as "yes".

B. Item Clarifications on the Profile - Home Version

1. Safety: Item A.2 - If the phone can't be found to see emergency numbers, should the observer ask where it is or should he/she code "no" ?

Observers may ask to see where the phone is located, then observe for emergency numbers.

2. Safety: Item B.3 - Should observers ask if water play activities do not occur?

Score this item based on observation of a water play activity, if no water play activity occurs then "--OR-- water play activity does not occur" would apply and score the item as "yes". Disregard the "R" under methods.

VII. The H.O.M.E Inventory

A. Clarification Regarding Specific Items

1. Item #16:

On both the home and child care versions of the H.O.M.E. item #16 reads - Caregiver/parent encourages child to talk and takes time to listen. The manual (Chapter 28.3) states that the key word is encourages. Even so, some three year old children do not need to be encouraged to talk. If this is the case AND THE CAREGIVER/PARENT ACTUALLY TAKES TIME TO LISTEN TO THE CHILD, then this item may be scored as "yes".

If the caregiver/parent reports that the child does not talk much, then visitors must probe and interview to determine if the parent/caregiver actually encourages the child to talk daily AND listens to the child before scoring "yes".

What we are really trying to capture here is the fact that someone is really taking the time to see that the child has a chance to discuss what is important to him/her and is listened to by an appropriate person. For children who do not start talking "about their day" on their own, then the appropriate adult in the situation (home or child care setting) must try to get them to do this (encourage). If, on the other hand, the child can and does start talking "about his/her day" spontaneously (and does so most of the time), then as long as the appropriate adult in the situation listens, then the intent of the item is met.

In the case of the children who do not need to be encouraged to talk, it would be wise to probe for how frequently this occurs and the amount of time the adult actually spends listening.

2. Items #42, #43, #44, #49, #50, and #53:

Can these items be scored from observation if they are observed during the fourth ORCE cycle and/or the interview portion of the H.O.M.E.?

These six items cannot be scored "yes" from observation. They are all interview items. You may, however, score a "no" for items #42 and #43 if they are observed during the fourth ORCE cycle and/or the interview portion of the H.O.M.E. It is also possible that a "no" can be scored from observation for items #50 and #53, though this is not recommended for two reasons. First, it is an interview item and should be dealt with as such, and second, it is always possible that the routine is somewhat different on that particular day (i.e.,due to the observer's presence, staff shortage, extra children,etc.).

There are several things that observers can do to make interviewing for these items shorter and quicker. Observers will visit the child care arrangement two days though the H.O.M.E. does not begin until well into the second day. Observers should recall what they have seen regarding these items from these two days. Although the observers CANNOT score from what is seen on the first day or during the first three ORCE cycles of the second day, they can use such information to start probes while interviewing. For example, on the first day the observer may notice that all of the children eat lunch together. Item #53 might then be approached by saying, "Yesterday I noticed that all of the children were eating lunch together, is that your usual routine?" In this case the observer has not scored #53 from out of the observation/interview portion of the H.O.M.E., but the observer has reminded the caregiver of what the caregiver did and has let him/her know that the observer is wondering if this is the usual routine.

3. Item #41:

Sites were wondering if since this item usually does not occur during the fourth ORCE cycle or the interview portion of the H.O.M.E. if observers could score it based on an introduction that was made on the first visit or the beginning of the second visit when the observer first arrived at the arrangement. Please note that this item, like all the others, may only be scored during the fourth ORCE cycle or the interview portion of the H.O.M.E. This item will be dealt with statistically.

B. Electronic/Computerized Toys

This section deals with how to handle the electronic/computerized toys that may be used by the child to self teach various skills. (An example is a toy which can be turned on with a button and has a card that is slipped into a slot. The toy will then instruct the child to press the yellow button. Once a button is pressed the toy will then tell the child whether or not s/he was correct.) Some of these toys have a variety of "cards" and cover several areas such as colors, numbers, shapes, letters, etc. If a situation is encountered in which the child has access to these kinds of toys, the observer may credit the mother or caregiver (depending upon the situation you are visiting), provided that she taught or helped teach the child how to use it and the child is in fact using the toy at least once every two weeks. The item that the observer would credit for the toy would depend upon the type of skill(s) that the toy teaches.

If the toy teaches several skills, the observer may count it as one toy for each of the skills, provided that the mother or caregiver taught or helped teach the child how to use it and the child uses it for each of the skills at least once every two weeks. For example, a toy that has cards for colors, numbers, and shapes would count as one toy for item #1 (colors and shapes) and one toy for item #6 (numbers).

Remember that each of the toys alone, for item #1, do not have to teach all three areas. Though there must be two or more toys which will cover all three areas in order to credit the item. There may be a donut shape sorter which is used for teaching color and shape and a donut stacker which is used for teaching sizes. This would be two toys which teaches all three areas and therefor credit may be granted to item #1. There may also be a book that teaches shapes, a game that teaches color, and a puzzle that teaches sizes. In this case there are more than two toys which teach all three areas, and therefore, credit may be given for item #1.

VIII. Cross-Site Reliability Data

A. Collecting Cross-Site Reliability Data

For cross-site, child care reliability data collection there will be two visits conducted in center based care and two visits conducted in FORMAL family care. The travelling RA should be different from the RA who visits at the home site with the RA from the travelling site.

B. Sending Cross-Site Reliability Data

When sending reliability data to the DCC please mark all cross-site reliability as "cross-site reliability" and within site reliability as "within site reliability". For cross-site reliability data please do the following:

- send in live data with regular data
- send in reliability data separate and marked
- for the coder ID please write the site number to the left of the coder ID - we will need to identify coders by site
- for practice families put an "8" in the second digit of the child ID, arrangement/center ID, and caregiver ID

- for practice families, send all of the data together as cross-site reliability, as there is no real data to pull out for these families
- sequence the numbering of the practice families for identification purposes

CHAPTER 27

Section 1

ADMINISTRATION OF 36-MONTH CHILD CARE VISITS

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Chapter 27

Section 1

ADMINISTRATION OF CHILD CARE VISITS (36 MONTHS)

I. PURPOSE OF THIS CHAPTER

This chapter provides guidelines for the child-care assessment visits to assure that these visits are conducted in a standard way across the ten sites participating in the NICHD Study of Early Child Care. In addition, it will serve as the archival description of the methods used in the child care data collection. Amendments or suggested revisions should be addressed to Deborah Phillips, the chair of the 36-month child care sub-committee, Bonnie Knoke at the Data Center, and to the person responsible for overseeing the particular procedure or measure. We acknowledge the help of Deborah Phillips (primarily responsible for Profile, and interviews); Kathleen McCartney and Alison Clarke-Stewart (primarily responsible for behavioral observations and questionnaires); Deborah Vandell (primarily responsible for qualitative ratings); and Robert Bradley and Judith Brisby (primarily responsible for the Child Care HOME measure.); Marion O'Brien, Aletha Huston, Yvonne Caldera, and Kathy Zima (primarily responsible for the peer observation.) A special note of thanks is owed to Susan Dell for her help with the preparation of this manual.

It is vital to the success of the Study that the interview and observational data be collected in as identical a fashion as possible across sites. In this chapter, you will find suggestions about how to interpret both interview and observation items, as well as how to administer the interview and collect the observational data. These procedures must be followed by all research assistants to ensure the comparability of the data across sites.

We have attempted to consider as many questions and contingencies as possible. However, situations that we have not anticipated will arise during the course of data collection. When you are presented with a situation that is not covered in the manual, capture it as accurately as possible (e.g., write the caregiver's exact question about an interview item), then contact Bonnie Knoke at the Data Center. She will confer with the relevant individuals and give you a coding decision, an interpretational decision, or whatever is needed. Each of these new decisions will be recorded in an appendix to this manual that will be distributed to all sites (with immediate BITNET messages for on-going updates).

II. RECRUITMENT PROCEDURES

The overall recruitment strategy for child-care providers is based on a set of common guidelines and procedures. However, within these, flexibility and multiple approaches will undoubtedly be necessary. These procedures are described, in detail, in Chapter 25, Administration of the 35-Month Phone Interview.

This chapter picks up the process at the point that the provider/director is contacted. It presumes that the steps within the protocol for arranging the peer observation procedure that must **be completed before the first contact with the care provider/director, and before the scheduling of the first childcare visit have been carried out. (See Chapter 27 Section 2, III, Arranging Peer Observations.) Child care observers must be extremely aware of and adhere to the specific differences in scheduling procedures and timing of visits dependent upon whether or not a peer observation procedure will be done in the target child's child care setting.** In general, the common guidelines are, first, to ask the mother during the 35-month phone call for permission for us to contact the child-care provider directly, and, second, to ask the mother to contact/persuade the caregiver if our attempt to get the mother's permission to make the first call fails or if our first attempt to obtain the caregiver's consent to visit is unsuccessful.

A. Child-Care Recruitment: General Approach

You must first determine whether the target child has a primary provider and, if so, the identity of this provider. This information is contained in the 35-month telephone interview data.

PRIMARY CHILD CARE ARRANGEMENT:DECISION RULES

Child must be in the primary arrangement 10 hours a week or more (Q32), typically awake for 3 hours on days used (Q33), and must have been enrolled for at least 2 weeks prior to the child care visit (Q36 gets age in months when enrolled. We will confirm the 2-week requirement when the child care visit is scheduled).

If mom cares for child at home (Q19[1]), other non-sibs who live in another household must be present 20 hours per week (YES to Q20, Q21, and Q22).

If mom takes child to work (Q19[2]), she must work in a child care center (Q23[1]) or another adult must regularly spend 10 hours per week with baby as a sitter (YES to Q25).

When multiple arrangements meet these criteria: (Use these decision rules hierarchically.)

1. Use arrangement with most hours of care per week (see Q32), including only those arrangements where child is typically awake for at least 3 hours.
2. If comparable hours (plus or minus 5 hours per week), use most "formal" arrangement: group program, home-based program, non-relative, relative other than father, father (see Q26).
3. If comparable hours in same type of arrangement, use arrangement in which child has been enrolled the longest (see Q36).
4. If all else is equal, use morning arrangement, unless CHILD has been enrolled in afternoon arrangement for at least one month longer (see Q34).
5. If all else equal, pick primary arrangement randomly.

If there is no primary provider, there are no child care visits. **You must still determine whether or not a peer observation procedure in an alternative setting can be done. (See Peer Observation Procedure in Alternative Setting in this section of Chapter 27 and all subsections dealing with the peer observation in alternative settings within Chapter 27, Section 2, Peer Observation Manuals.** If there is a primary provider, invoke the scheduling procedures for centers and homes (including care in the child's own home or another home, by a relative or non-relative), described below. This should be done as soon as possible after the 35-month telephone interview is completed.

You will then use one of two approaches for contacting the provider. The preferred approach is to contact the primary child care provider (homes) or director (centers) directly. The alternative approach is to have the mother contact the provider/director prior to your contact.

The specific goals of this initial contact, however, will vary depending upon whether or not the caregiver has been seen before, how receptive the caregiver sounds as you are talking with him/her, whether or not the peer observation procedure is going to be possible in this setting, and finally, whether or not the caregiver will need to be enlisted in order to identify appropriate peers for the peer observation procedure.

Sometimes mothers will give you information about their child care arrangement during the 35-month call that is later contradicted by the caregiver when you call him/her to set up an observation. In general, it is good practice to try to reach the mother and to clarify the contradictory information. So, for example, if you call the caregiver and learn that he/she stopped caring for the target child "2 weeks ago", you will need to talk with the mother about her current arrangements. In fact, you should complete a new 35-month phone call if you learn that her situation has changed. **The 35-month phone call should not be mailed to the Data Coordinating Center until the child care visits have been completed.**

If the care arrangements are new, you should not collect any child care data until the target child has been in this setting for at least two weeks. The same 2 week waiting period should also be adhered to in cases where the caregiver has been absent for two or more weeks (vacations, illness, etc.). If you determine that this arrangement does not or cannot meet our criteria for observable child care within the regular collection window, find out if there is a secondary arrangement that meets the criteria for observable care. If there is none and you are at the 41 month, conduct the appropriate Child Care Interview with the caregiver over the phone, or the Mother Telephone Interview About Child Care for Home Arrangements We Cannot Visit as a last resort. It is preferable to have some rather than no child care data for this assessment period. (See D. 5. Information About Care From the Mother Contradicts Information She Has Given on the 35-month Phone Call).

Finally, if the child care hours are all in the evening or at night, make sure that the target child is up for at least 3 hours on a typical day, otherwise the arrangement does not meet our criteria for observable child care. Never ask a caregiver (even a parent) to wake up a child.

The windows for the two 36 month child care visits are as follows:

	36 Month Visit
Schedule between	36 months, 0 days to <38 months, 0 days
Exception period	38 months, 0 days to <41 months, 0 days
No data on or after	41 months, 0 days

All data collected during the exception period must have the written approval of a principal investigator. Fill out the EXCEPTION PERIOD DATA COLLECTION APPROVAL form and have the principal investigator sign it. Because of the danger of cancellations all visits should be scheduled as early in the window as possible.

Other scheduling constraints for the child care visits are:

- First child care visit should be as close as possible to 36 months, 0 days.
- Second child care visit should be within 1 week of the first visit. Occasionally, as long as 2 weeks after

the first visit may be required, if needed to accommodate the peer observation procedures (unless this would put the second child care visit on or past 41 months, 0 days). We strongly advise, however, that this gap be kept to 1 week, even when the peer observation is conducted on the second visit.

- Do not schedule any visits before the target child has been enrolled in the arrangement for at least two calendar weeks. Even if the child is in the arrangement only 2 days per week, for example, use this 2 week criterion.

Thank the provider/director for being part of the study and mail out the appointment confirmation letter, the description of the study and visits (if not already sent), and if required at your site, the consent form. Center directors will also be sent the Director Questionnaire and Background Information Questionnaire (see Center Recruitment, below). Some sites may wish to send out the description of the study and visits after the 35-month phone call and before the child care visitor contacts the provider.

If you cannot reach the provider/director by phone, send the RECRUITMENT letter and STUDY DESCRIPTION. Then follow-up with another call or ask the mother to have the provider call you.

The day of (or before, if very early in the morning) the first scheduled appointment, call the provider/director to confirm the visit.

If the provider/director refuses a visit, information about the arrangement should be obtained over the telephone using either the appropriate caregiver interview -- if s/he is willing to be interviewed, or the Director Telephone Interview for Centers We Cannot Visit (11B), or the Mother Telephone Interview for Home Arrangements We Cannot Visit (11C).

CENTER-BASED CARE CONTACTING THE DIRECTOR

STEP 1 Child care coordinator (or person responsible for scheduling child care visits) contacts the center director OR mother contacts the center director.

STEP 1B IF MOTHER CONTACTS DIRECTOR, coordinator recontacts mother for update, then contacts director.

STEP 2 Coordinator schedules one or both visit(s) (if no Peer Observation Procedure possible) and asks the director to inform all classroom staff who provide care for target child about the study and the timing of the visit OR follows director's advice to contact the staff directly.

STEP 3 Conduct the Director Telephone Interview (Form 11A).

STEP 4 Send (a) letter confirming the visits, (b) study description, and (c) director questionnaires (Form 11T and Form 11D or 11U). If required at your site, also send the consent form.

STEP 5 Call director the day of (or before, if very early in the morning) the actual observation to reconfirm the visit and make sure the target child is there. Remind him/her to complete the director questionnaires.

IF THE DIRECTOR REFUSES THE VISIT, ask his/her permission to conduct the "DIRECTOR TELEPHONE INTERVIEW FOR CENTERS WE CANNOT VISIT". If he/she refuses, do the interview with the mother. Try to get the most accurate information possible, in this instance. This may necessitate mailing the mother a copy of the interview if there are several items she is uncertain about. Set up a time to call the mother back after she has obtained the needed information.

HOME-BASED CARE (including in-home care by fathers and other relatives) CONTACTING THE PROVIDER

STEP 1	Child care coordinator (or person responsible for scheduling child care visits) contacts the provider OR mother contacts the provider.
STEP 1B	IF MOTHER CONTACTS PROVIDER, coordinator recontacts mother for update, then contacts provider.
STEP 2	Coordinator schedules one or both visits (if there is no Peer Observation procedure possible) with provider
STEP 3	Send (a) letter confirming the visits and (b) study description. If required at your site, also send the consent form.
STEP 4	Call provider the day of (or before, if very early in the morning) the actual observation to reconfirm the visit and to make sure the child is present and well.

IF THE PROVIDER REFUSES to be observed, ask if she/he would be willing to do just the caregiver interview over the phone. If not, conduct the Mother Telephone Interview About Child Care for Home Arrangements We Cannot Visit (Form 11C) with the mother. Ask her to find out from her provider any information about which she is uncertain or does not know. Call her back for this information at an agreed upon time.

The following two sections - CENTER RECRUITMENT and HOME RECRUITMENT - elaborate these procedures for these differing types of arrangements and for situations in which the caregivers need to be used to identify appropriate peers for the peer observation procedure. In some cases, it will not be clear whether an arrangement is a center or home. Consider it a home if the setting is used as a residence, even if it resembles a center in room arrangements, numbers of children, etc. This will often be considered a "Group Family Day Care Home" by licensing officials.

B. Center Recruitment

1. Contacting the Director

Contact the center director by phone as soon as possible after getting information about the child's care arrangement from the 35-month phone call or after the mother's contact with the director **and, after first checking the Peer Observation Worksheet to see whether there are eligible peers for the peer observation.** If your site prefers to send the literature to the director and then make the phone call, that is allowable. But be aware of the window for the child-care assessment (36 months to less than 38 months).

In the phone call, briefly explain the study, summarize what is involved on the directors' and teachers' parts, answer any questions, and obtain an initial verbal consent. Also explain to the director that all of the staff who provide care for the target child need to be informed about the study and they will need to sign the consent form. Offer two approaches: the director may contact the staff or you may contact them directly. Do what the director suggests. If you cannot reach the director by phone, send the RECRUITMENT LETTER AND STUDY DESCRIPTION and follow up with another call or ask the mother to have the director call us.

If you determine from the Peer Observation Worksheet that there are eligible peers for the peer observation in the target child's group and you have been able to contact them and get permission from their parents through information given by the mother, tell the director.

If you have been unable to identify, contact, or get at least verbal consent from parents of eligible peers based upon the information on the Peer Observation Worksheet, explain during this call to directors who are open and receptive to our observing in their center, that you will be asking the child's caregiver(s) to help in determining eligible peers and contacting those peers' parents. In most instances, however, it is recommended that his subject be broached at the end of the first child care visit (see chapter 27, Section 2, III,B for detailed instructions).

If the director says "no" to the child care at this point, try to find out why. You may be able to assuage his/her concerns. Ask if you might send the materials (RECRUITMENT LETTER AND STUDY DESCRIPTION) and call him/her back. Ask if you may just ask a few questions over the phone either now or later (preferably now). Explain that it will take about 15 minutes (see below: 3. When it is not possible to do the Child Care Assessment). If the provider is adamant, we cannot force ourselves upon him/her. We will then have to use the mother as our sole informant about the child's care arrangement (see below).

In addition, in cases of refusal, if the child has a secondary arrangement in which he/she is enrolled for at least 10 hours a week, call the mother back and ask if we can repeat the recruitment process for this provider.

Talking Points for Child-care Recruitment

Following is a list of "talking points" for Child-care Recruitment. Adapt these talking points, as appropriate, for centers you have already visited.

* Explain the overall purpose of the study using the consent form as a guide. For example: children are growing up under very different circumstances today; child care has become a

very important part of most children's lives; we need to understand how this affects children's development; etc. Note national significance, importance to children and families, child care providers etc.

- Describe the visit from the provider's perspective:
  - Two days of visits;
  - Three hours each;
  - Prefer mornings, if target child is typically awake then;
  - We will start by talking briefly with director, and then go immediately to the target child's classroom.
  - Most of our time will be spent observing the target child. THIS DOES NOT REQUIRE ANY CHANGES IN YOUR TYPICAL ACTIVITIES. The only time we will ask for any special activities is if a 15-minute observation of STUDY CHILD with another child is to be done in this setting.
  - We will also be observing the target child's classroom.
    - And, we will interview up to 2 of the child's providers (about 30 minutes each as part of the 3-hour visit.)
- All procedures will be maximally convenient for the provider (we can be flexible).
- All data are confidential (nothing is reported to any licensing agency. Our purpose is research, not evaluation). The only thing we would need to report is child abuse.

* We will be paying $40 for his/her/their participation. (In cases of multiple providers, find out how the director would like this to work, e.g., divide among providers, program gift, etc.).

* Complete TELEPHONE INTERVIEW, with the director.

* Again, stress the importance that he/she talk to his/her staff who take care of the target child. You may need to volunteer to visit in advance.

The following is a sample telephone script to be used with centers that includes the points mentioned above:

Script for Caregiver Phone Call (Center Care)

"Hi. My name is ________. I am on the staff of the NICHD Study of Early Child Care. (If you have already visited center, say, "You may remember that we observed CHILD at your center when he/she was 24 months old" or "You may remember, we observed OTHER CHILD at your center recently.") CHILD'S NAME who attends your center has been part of our study since birth. I sent you a letter last week describing the study. Did you receive it?

IF DIRECTOR DID NOT RECEIVE THE INFORMATION, THEN DESCRIBE THE STUDY. *The study seeks to learn how different people and places affect children's development. Because child care is such an important part of many children's lives, we want to observe children in their child care setting. Children in the study are visited in their homes and child* *care settings when they are 6, 15, 24, and 36 months old. I would like to come to observe CHILD when he is at your center when he/she is about 36 months old.*

Let me give you an overview of what I would like to do. When CHILD is about 36 months old, I would like to visit your center for a couple of mornings. The first morning I would start by talking briefly with you (director) and going over your answers to a brief questionnaire that I will have sent you ahead of time. (It just asks a few questions about the center.) I would then go to CHILD'S room. Most of my time in the room would be spent observing CHILD in his/her room's typical activities. Before I go, I will leave some brief questionnaires for them to fill out before I return, if possible. On the second day, I would again observe CHILD in her/his room, and I would also bring some special toys and spend about 15 minutes videotaping CHILD playing with one friend. I would also interview (for about 30 minutes) a maximum of 2 of CHILD'S providers. Finally, I would pick up the brief questionnaires I left at the first visit for them to fill out.

Of course, all information we collect is confidential. We are not part of any licensing agency.

In appreciation for your participation in this project, we would like to provide your program with $40. It can divided among the child's providers or as a gift to the program, whichever you prefer.

May I schedule these visits? (or only first visit, if necessitated by peer observation)

IF YES, Do you know CHILD's schedule well enough, or should I talk with someone else? I need to come at a time when CHILD will be awake for about two and one half hours. I would like to come in the mornings if possible.
SCHEDULE VISIT IF POSSIBLE.

IF NO, *Would you like for me to send you additional information about the study?* SEE PROBLEM SOLVING SECTION.

I will be sending you some information to look over, two brief questionnaires I'd like you to complete before I arrive if that is possible, and also a letter confirming the visit dates and times.

Also, I'd like to get a little information about CHILD room before I come. START DIRECTOR TELEPHONE INTERVIEW (For notes on specific questions, see p. 77.)

Thank you for your time.

2. Scheduling the Visit

If the director says "yes", schedule a visit, using the following questions:

(1). When you are speaking to the director of a center, ask if she knows the child's schedule well enough to be able to schedule the visit. If not, ask if you should speak to the child's caregiver to get the best times. Also ask the director the questions on the DIRECTOR TELEPHONE INTERVIEW (From 11A). Then, ask the appropriate individual, "*In your opinion, considering your schedule and the CHILD'S, what would be the best time for us to schedule a visit? I need to see the CHILD when he/she is most likely to be awake and not likely to be interrupted by someone coming to visit. I will need to make two visits of about three hours each*".

The child is most likely to be awake and available in the morning, so if you have a choice, please schedule the visit so that it occurs predominantly during the morning hours. Of course, some children will not be in child care at all during the morning. And, you may wish to schedule the second visit so that your interview time coincides with the children's nap time or the caregiver's break.

(2) Next determine what day(s) of the week is best for the caregiver. Do not observe children until they have been in the center (and the same classroom) for at least 2 weeks.

Aim for a first visit as close to the child's 36-month birthday as possible. It is extremely important that the child-care visit be scheduled within its 2 month window. In this context, be aware that extra time may be needed to secure names of, and permission from peer for the peer observation in child care settings. Schedule the visit at a time that the child's REGULAR caregiver(s) will be there. (Accept no substitutes!) If the regular caregiver is absent in either visit it will have to be rescheduled.

If a peer observation will be done **and permission has already been secured by the peer's parents**, schedule the second visit when the appropriate peer will be there.

In settings where _no_ peer observation procedure is possible, schedules should aim for the second child care visit to be within 2 weeks of the first child care visit and preferably within one week. If the mother has identified appropriate peers in this setting but you have not yet received permission from their parents, or if the caregiver will have to be enlisted to identify appropriate peers for the observation, YOU CANNOT SCHEDULE THE SECOND VISIT AT THIS TIME. For these reasons, the second child care visit can be as long as 2 weeks after the first visit in order to accommodate the peer observation procedures.

(3). Select times and dates for one or both visits, and include this information in the confirmation letter to the director.

Thank the director for being a part of the study and tell him/her that:

(1) You will call back the day of the visit to confirm the appointment and to make sure the child is there;

(2) The director should receive, before your visit, a letter confirming dates and times of the visits and a description of the Study and the visits. Tell the center director that he/she can post this description for parents to see, if he/she wishes;

(3) If your site requires that a consent form be sent in advance, tell him/her that this also will be included with the letter.

(4) He/she will also receive, with the letter, 2 brief questionnaires (DIRECTOR QUESTIONNAIRE [Long-Form 11D or Short-Form 11U] and CENTER DIRECTOR BACKGROUND INFORMATION QUESTIONNAIRE [Form 11T]) that you would like him/her to fill out before the visit. Explain how to fill out the questionnaires. If the Director has been visited before see page 69, the section on which forms to use when a child care arrangement has been visited before.

(5) Make sure that the director will communicate the information about the visit to the staff in the child's room. Offer to talk directly to the staff before the visit if he/she thinks this would be wise. Remind her that these staff will need to sign the consent form, along with the director, in order for you to collect any data.

You will then send:

(1) the confirmation letter;

(2) the description of the Study and visits;

(3) the Director's Questionnaire and Background Information Questionnaire(Long or Short); and

(4) a consent form (if required at your site).

3. When it is Not Possible to Do the Child-care Assessment.

You need to conduct a separate telephone interview to obtain crucial information about the target child's child-care arrangement. This interview will ideally occur with the center director, but may occur with the mother, if the director refuses.

The "Director (or Mother) Telephone Interview for Centers We Cannot Visit" is used if either the mother does not want us to observe in the center or the center policy does not allow us to observe. It is used instead of the regular Director Telephone Interview, the regular Director Questionnaire, and the Child Care Observation. If the director refuses to be interviewed, use the "Director (or Mother) Telephone Interview for Centers We Cannot Visit" with the mother. If the mother is the respondent and she does not know the answer to any of the questions ask her to find out and you will call back later. (You can send her a copy of the questions to help her remember what to ask.)

The forms (11B and 11C) for interviewing center directors\ mothers who will not permit an on-site center/home visit contains a space for filling in the center/arrangement ID. IT IS ESSENTIAL THAT YOU ASSIGN IDS TO ALL CHILD CARE ARRANGEMENTS, WHETHER VISITED OR NOT. Please write in a Center/Director or Arrangement ID number using the instructions for assigning all IDs.

A validity check will be performed on these interviews, by having a subset of study sites conduct the interviews with directors/mothers on whom we also collect live data.

4. Confirmation Phone Call to Director

The day of the scheduled appointment, call the director or caregiver to make sure all the principal actors are present and accounted for, and that there is not an unforeseen problem giving you a reason to postpone the visit. Make sure the child and the child's primary caregiver are present. If they are not, find out from the director/caregiver how long the child or the primary caregiver will be away and then reschedule your visit accordingly.

Make sure that the center director will have completed the Director's Questionnaire before your visit. Answer any questions he/she has about the questionnaire or the visit. Make sure that the director has informed the staff in the child's room of your visit and that she or someone else in authority will be there to sign the consent form for the director when you come. If he/she will not be there, make sure that it will be OK for someone else on the staff to sign for her. Ask her to have the classroom caregiver call you directly if she has any questions about your visit, and then be available to take the call.

5. Obtaining Consent

Consent should be obtained from the director and from individual caregivers as well, after you arrive at the site and before you begin your observations.

In some cases, caregivers may be less than 18 years of age. It is very important that you include these caregivers in the child care assessments. Sometimes, the child's only caregiver will be under 18 years of age. Other times, the child will have multiple caregivers, one of whom is under 18 years of age.

This poses a question for the consent forms. You should clarify procedures with your human subjects committee. In some cases, it may be necessary to obtain the consent of the caregiver's parent. Perhaps this consent can be obtained over the telephone. Perhaps it is required only if the under age caregiver is not being supervised by an older caregiver. You will need to get answers to these questions for your site. But, we repeat, we need data on these caregivers -- they are a particularly interesting group.

6. Center Payment

Each participating center will be paid $40 at the end of the second visit. (Some sites may wish to assure that all questionnaires are completed prior to payment.) For centers you will need to ask the director how he/she wishes to handle the payment. Some may wish to divide the payment equally among all participants; others may wish to purchase a gift for the center. Please be as flexible as you can.

C. Home Recruitment

1. Contacting the Provider

Contact the primary child-care provider by phone as soon as possible after getting information about the child's care arrangement from the mother or after the mother's contact with the provider and after first checking the Peer Observation Worksheet to see whether there are eligible peers for the peer observation in this setting. If your site prefers to send the literature to the child-care provider and then make the phone call, that is allowable. But be aware of the window for the child care assessment (36 months to less than 38 months .) In the phone call, briefly explain the study, summarize what is involved on the providers' part, answer any questions, and obtain an initial verbal consent.

If you cannot reach the provider by phone, send the RECRUITMENT LETTER AND STUDY DESCRIPTION and follow up with another call or ask the mother to have the provider call us.

If the provider says "no" at this point, try to find out why. You may be able to assuage his/her concerns. Ask if you might send the materials (RECRUITMENT LETTER AND STUDY DESCRIPTION) and call him/her back. If the provider is adamant, we cannot force ourselves upon him/her. We will then have to use the mother as our sole informant about the child's care arrangement (see below).

In addition, in cases of refusal, if the child has a secondary arrangement in which he/she is enrolled for at least 10 hours a week, call the mother back and ask if we can repeat the recruitment process for this provider.

Talking Points for Child-care Recruitment

Following is a list of "talking points" for Child-care Recruitment. Adapt these talking points, as appropriate, for homes you have already visited.

- Explain the overall purpose of the study using the consent form as a guide. For example: children are growing up under very different circumstances today; child care has become a very important part of most children's lives; we need to understand how this affects children's development; etc. Note national significance, importance to children, families, and providers.
- Describe the visit from the provider's perspective:
  - Two days of visits;
  - About 3 hours each;
  - Prefer mornings, if target child is typically awake then;
  - Most of the time will be spent observing the target child. THIS DOES NOT REQUIRE ANY CHANGES IN YOUR

TYPICAL ACTIVITIES. In fact, we don't want anythin unusual to happen; the only time we will ask for any special activities is if a 15-minute observation of STUDY CHILD with another child is to be done in this setting.

- ** We will be observing the environment in which the child spends his/her time.
- ** And, we will conduct an interview with you (about 30 minutes)

- * All procedures will be maximally convenient for the provider (we can be flexible).
- * All data are confidential (Nothing is reported to any licensing agency. Our purpose is research, not evaluation). The only thing we would need to report is child abuse.
- * We will be paying $40 for his/her/their participation. (In cases of multiple providers, find out how they would like this to work, e.g., divide among providers, program gift, etc.).

The following is a sample telephone script, for family day care, that includes the points mentioned above.

Script for Caregiver Phone Call (Family Day Care)

"Hi. My name is ________. I am on the staff of the NICHD Study of Early Child Care. (If you have already visited the home, say, "You may remember that we observed CHILD at your home when he/she was 24 months old" or "You may remember, we

observed OTHER CHILD *at your home recently.")* CHILD *who you care for has been part of our study since birth.* IF SENT INFORMATION AHEAD OF TIME, *I sent you a letter last week describing the study. Did you receive it?*

IF THE CAREGIVER DID NOT RECEIVE THE INFORMATION, THEN DESCRIBE THE STUDY. *The study seeks to learn how different people and places affect children's development. Because child care is such an important part of many children's lives, we want to observe children in their child care setting. Children in the study are visited in their homes and child care settings when they are 6, 15, 24, and 36 months old. I would like to come to observe* CHILD *when he/she is in your care when he/she is about 36 months old.*

Let me give you an overview of what I would like to do. When CHILD *is about 36 months old, I would like to visit you a couple of times. The first visit I would spend most of my time watching what the child does when he/she is in your care. For part of this time I will focus exclusively on the* CHILD *and for other parts of this time I will watch the surroundings of the* CHILD *so that I can get a good sense of the kinds of experiences that s/he can have, but that I don't happen to see during my brief visit. This would not require any changes in your typical activities.*

At the end of the first visit I would leave you (both) some brief questionnaires to be completed when you are able. I would pick them up at the second visit. On the second day, I would also talk to you (and your helper) near the end of my visit for about 35-45 minutes about your background experience and about how you handle child care.

(If you know that the peer observation procedure will be or can potentially be done in this setting, inform the careprovider that you will bring some special toys and spend about 15 minutes videotaping CHILD playing with one friend.)

Of course, everything is confidential. We are not part of any licensing agency.

In appreciation for your participation in this project, we would like to provide you (and your helper) with $40. (That is, $20 for each of you.)

Is it okay if I come?

IF YES, *Great! I need to come at a time when CHILD will be awake for at least two and one half hours. I would prefer to come in the mornings if possible but this is not essential.*

SCHEDULE VISIT IF POSSIBLE.

IF NO, *Would you like for me to send you additional information about the study?* SEE PROBLEM SOLVING SECTION.

I will be sending you a consent form for you to look over and also a letter confirming the visit dates and times.

Thank you for your time.

2. Scheduling the Visit

If the provider says "yes", schedule a visit, using the following questions:

(1). "*In your opinion, considering your schedule and CHILD's, what would be the best* *time* *for us to schedule a visit? I need to see CHILD when he/she is most likely to be awake for at least two and one half hours and not likely to be interrupted by someone coming to visit. I will need to make two visits of about 3 hours each*".

The child is often most likely to be awake and available in the morning, so if you have a choice, please schedule the visit so that it occurs predominantly during the morning hours. Of course, some children will not be in child care at all during the morning.

(2). What day of the week is best for you? Do not observe children until they have been in an arrangement for at least 2 weeks. Aim for a first visit as close to the child's 36-month birthday as possible. It is extremely important that the child-care visit be scheduled within the 2 month window. Between 38 months and less than 41 months, 36 month visits may be conducted, but flagged as exceptions. On or after 41 months a 36 month child care visit is not conducted.

Schedule the visit at a time that the child's REGULAR caregivers will be there (no substitutes). If the child's regular caregiver is absent for either visit, it will have to be rescheduled.

In settings where no peer observation procedure is possible, schedules should aim for a second child care visit to be within one week. If a peer observation will be done, and permission has already been given by the peers' parents, schedule the second visit when the appropriate peer will be there. In cases where you must enlist the child care provider's help in identifying appropriate peer(s), schedule only the first visit. This situation will arise if the mother has identified peers in this setting but permission has not been obtained, or if the mother has been unable to identify any appropriate peers. (See Chapter 27, Section 2, III, A, B, & c).

(3). Select times and dates for one or both visits, and include this information in the confirmation letter to the provider.

Thank the provider for being a part of the study and tell him/her that:

(1) You will call back the day of (or before, if very early in the morning - this is not preferable) the observation appointment to confirm the appointment and make sure CHILD is there;

(2) Before your visit the provider should be sent a letter confirming the visits and a description of the Study and the visits. If appropriate, tell the provider that he/she can post this description for parents to see, if he/she wishes;

(3) If your site requires that a consent form be sent in advance, tell him/her that this will also be included with the letter.

You will then send:

(1) the confirmation letter;

(2) the description of the Study and visits;

(3) a consent form (if required at your site).

3. When it is Not Possible to Do the Child-care Assessment

You need to conduct a separate telephone interview to obtain crucial information about the target child's child-care arrangement. If the mother will not allow us to contact the provider in a home-care arrangement, ask her to complete the Mother Telephone Interview for Home Arrangements We Cannot visit. If the home caregiver refuses to be visited, ask her/him if s/he is willing to do just the appropriate caregiver interview over the phone. If so, do it. If not conduct the mother telephone interview as above. If the mother is the respondent and she does not know the answer to any of the questions, ask her to find out. You can send her the questions to help her remember what to ask.

The forms (11B and 11C) for interviewing center directors/mothers who will not permit an on-site center/home visits contain a space for filling in the center/arrangement ID. IT IS ESSENTIAL THAT YOU ASSIGN IDS TO ALL CHILD CARE ARRANGEMENTS, WHETHER VISITED OR NOT. Please write in a Center/Director or Arrangement ID number using the instructions for assigning all Ids.

A validity check will be performed on these interviews, by having a subset of study sites conduct the interviews with mothers on whom we also collect live data.

4. Confirmation Phone Call to Provider

The day of the scheduled appointment (or, if very early in the morning, call the day before), call the provider and confirm that the date for the observation is still okay and that the child is there. Answer any questions he/she has about the visit.

5. Obtaining Consent

Consent will be obtained from the provider and from any additional helpers/providers who are observed, after you arrive at the site and before you begin your observations.

In some cases, caregivers may be less than 18 years of age. It is very important that you include these caregivers in the child care assessments. Sometimes, the child's only caregiver will be under 18 years of age. Other times, the child will have multiple caregivers, one of whom is under 18 years of age.

This poses a question for the consent forms. You should clarify procedures with your human subjects committee. In some cases, it may be necessary to obtain the consent of the caregiver's parent. Perhaps this consent can be obtained over the telephone. Perhaps it is required only if the under age caregiver is not being supervised by an older caregiver. You will need to get answers to these questions for your site. But, we repeat, we need data on these caregivers -- they are a particularly interesting group.

6. Provider Payment

The provider will be paid $40 at the end of the second visit. (Some sites may wish to assure that all questionnaires are completed prior to payment.) For family day-care homes with more than one provider who has been involved, you will need to ask the owner how he/she wishes to handle the payment. Some owner may wish to divide the payment equally among all participants; others may wish to purchase a gift for the home. Please be as flexible as you can.

D. Problem Solving

1. Trouble Making Contact With Caregiver/Director.

The caregiver or the director of the center is not available when the project staff person calls. A person other than the caregiver (home daycare) or director (center daycare) answers the phone or a machine answers the phone:

"*Hello. This is (your name) from the Study of Early Child Care. (Name of child) is in (name of provider's) care. (Name of child) and his/her mother are part of a study on early child experiences and development. (Name of mother) and (name of child) have been participating in the study since (name of child)'s birth. (Name of mother) has contacted caregiver/provider (or you) about the possibility of observing (name of child) while he/she is in (name of caregiver/director/your) care. Could (he/she) (you) please call me back today or tomorrow at the following number:* ."

If speaking to a person add:

"*I am sure he/she is very busy so I hope it's okay for me to call (her/him) back if I don't hear from (her/him). Is there a good time when I might reach (her/him) today or tomorrow? Thank you. Bye.*"

Make the second phone call at the time suggested, or some time during the following day. If the caregiver/provider is still not available, leave another message asking that he/she get back to you within the day.

If the phone call is not returned after the second try (second day) and no reason is given for the caregiver/provider's unavailability, then follow up with a third call the following day (third day) to leave a third message.

If by the morning of the fourth day (at the latest), the caregiver/provider has not returned your call, and the mother has made the original contact, call the mother, asking her to approach the caregiver/provider again with the following message (we are not asking the mother to read this to the caregiver/provider, but to try to include the following points when speaking again with the caregiver/provider):

"As you may know (name of child) and I are involved in the Study of Early Child Care. The staff for the project would like to speak with you to discuss their study and your possible participation. They are having difficulty reaching you. I know you are very busy but they feel your input is very important to the study. Would you mind speaking with her/him within the next couple of days about the study and the possibility of a visit. Is there a good time for them to reach you to discuss the study and a possible visit?"

Alternatively, you could at this point send the RECRUITMENT letter and a note suggesting that the director call you at her convenience.

If the caregiver is still unresponsive, the project staff person could suggest that the mother ask the caregiver/provider if he/she would like to be introduced to the project visitor before he/she agrees to participate.

2. During Contact With the Caregiver/Director, the Provider Says "no" or is Ambivalent About Participation

Try to find out why. If the provider is adamant about refusing to discuss participation, we have a missing child-care observation. If the caregiver is willing to discuss refusal or is ambivalent about participation, use the following troubleshooting suggestions to encourage participation:

Discussing the study and its importance. Summarize what is in the Study Description, emphasizing its importance to children, its national significance, and the critical importance of caregiver provider participation in the study. If he/she has received the description, ask if he/she had a chance to read the description and if there are any questions about the study or his/her participation? Mention that the caregiver/provider/center will receive a payment of $40 at the end of the second visit in appreciation for their time and input.

Provider/Director is concerned the visit would be too disruptive to normal routines. Explain that:

- The date and time of the visits are arranged for the convenience of the caregiver/director;

- Our project staff person will be as non-intrusive as possible;
- Our primary purpose is to observe the child in normal circumstances. We do not want any special arrangements made for the visit (changes in schedule, etc.); (The only time we will ask for any special activities is if a 15-minute observation of STUDY CHILD with another child is to be done in this setting.)
- We understand your primary responsibilities are to the children;
- Although we do need to speak with you about your views and past experience, this brief interview can be at your convenience and you can request that we leave at any time, if you feel circumstances warrant it.

The caregiver/director is concerned about the privacy of the staff and other children and parents. Explain that:

- All observations and staff comments are kept confidential and are shared only with project staff (with the exception of child abuse);
- Any information from the observations or interviews will not be shared with the parent (of course, overall study results that do not identify any study participants will be made available to any interested caregiver/provider.);

- No information will be gathered for other children in their care, unless the other child's parent has signed the Peer Pull-out consent form.
- Any caregiver who is observed at a center is asked for consent prior to the observation. If conducting peer observation, add: The one other child to be observed will receive written parent permission before the observation.

Caregiver/Director wants to think about it first or discuss it further with the staff before giving consent or scheduling a visit. Ask for a specific time to call back to discuss their participation. If necessary, mention that we do have a time constraint in that we need to see the child as close as possible to his/her 36th month birthday. If all else fails, go back to the mother again and see if she can persuade the caregiver.

The caregiver/director seems concerned that you may report your findings to licensing officials. This is particularly pertinent to family daycare providers, some of whom are unlicensed and operating illegally. If you sense this is the source of a provider's hesitation, be explicit about the fact that you will not report any data or anything else that you hear or observe to licensing officials. All data are confidential. (The only reporting requirement with which you must comply concerns suspected child abuse or neglect.)

3. The Provider Takes Steps That Create an Atypical Day.

Providers may try to schedule your visits when other children are asleep, when some children are absent, or after a "problem child" has gone home. This may be a real problem in smaller, informal arrangements. If you get a sense that this is happening when you schedule or confirm the visits on the phone, you should reiterate the importance of seeing a typical day and address his/her concerns about being "tested" or about the disruptiveness of the visit.

More often, you will sense that the visit is atypical when you arrive to conduct your observation. There is little you can do at this point, unless you are willing to reschedule the visit (with no guarantee that the rescheduled visit will be more typical). In cases where the children are asleep at non-nap times and you sense that this has been done to accommodate your visit, try to wait until they wake up. There is a place on the Post Visit Interview and Ratings of the Caregiving Environment form to indicate whether you felt you have captured a typical day. Indicate "no" in these cases.

4. Information About Care From the Caregiver Contradicts Information From Another.

If the information from the caregiver contradicts the information from the mother, call the mother back to clarify. If necessary complete a new 35-month phone call (if you learn that the child care situation has changed). Do not send the 35-month phone call data from either call to the Data Center until the child care has been observed or the appropriate phone interview for setting we cannot visit has been conducted. At that point, send only the correct 35-month phone call data to the Data Center.

5. Information About Care From the Mother at the Home Visit Contradicts Information From the Mother on the 35-Month Phone Call

Sometimes during the home visits mothers will give information that may or may not contradict information from the 35-month phone call as well. For instance, they may mention that they have begun child care during the interim. Others may fill out the My Child Care (Form 15K), when, in fact, the care does not meet our criteria for observable care. In both instances the appearance of the completed My Child Care (Form 15K) should alert staff that a new 35-month phone call should be made so that the child care observation, if observable, may be scheduled.

These My Child Care forms require a caregiver ID before they may be sent to the Data Coordinating Center. In all cases they should not be sent to the Data Coordinating Center until after the child care observations or phone interview has been conducted so that the correct caregiver ID for the 36-month coding period is recorded on the form.

If, after seeking clarification from the mother, there is indeed not observable child care, the My Child Care form should be destroyed. **DO NOT send these My Child Care Forms to the Data Coordinating Center.**

III. ASSESSMENT PROCEDURES

A. General Procedures

This section covers general considerations for the child-care visits, including the determination of when the visit should take place, the "order" in which the data are collected, the determination of which caregiver(s) to observe in the case of multiple caregivers, and procedures in the case of a single arrangement being used by more than one Study child.

1. Number of Visits

All data collection should occur within two visits, unless there are circumstances that prevent the collection of the minimum required data in two visits and a third visit is necessary. You should do everything in your power to keep to 2 child care visits per arrangement. Do not return a third day, for example, to complete your fourth ORCE cycle unless this is absolutely unavoidable. Be careful not to overstay your welcome. Do not pressure caregivers to complete their interviews or to let you stay longer when it is obvious that your presence is not wanted.

2. Timing of Visits

The windows for the 36 month visits are as follows:

	36 Month Visit
Schedule between	36 months, 0 days to <38 months, 0 days
Exception period	38 months, 0 days to <41 months, 0 days
No data on or after	41 months

All data collected during the exception period must have the written approval of a principal investigator. Because of the danger of cancellations all visits should be scheduled as early in the window as possible.

Other scheduling constraints for the child care visits are:

- 1. First child care visit should be as close as possible to 36 months, 0 days
- 2. Second child care visit should be within 2 weeks of the first visit. Occasionally, as long as 4 weeks after the first visit may be required, if needed to accommodate the peer observation procedures (unless this would put the second child care visit outside the window). We strongly advise, however, that this gap be

kept to 2 weeks even when the peer observation is conducted on the second visit.

- Do not schedule any visits before the target child has been enrolled in the arrangement for at least two weeks, regardless of days/hours per week enrolled
- Try to schedule the second visit at a time when the peer to be observed with STUDY CHILD is likely to be present, unless the peer observation is being conducted on a third visit.

The scheduling of the visits should be worked out with the child care provider when the appointment is made. You want times when the child is as alert as possible. This most likely to be true in the morning, but, if not, schedule whenever the child is awake and alert for sufficient time to conduct the observations.

3. Confirming the Visit

Call to the director/provider on the day of (or before, if absolutely necessary) the visit to confirm the appointment and to be sure that the child is present.

4. When Child is Absent

If you arrive and you discover the child will be absent that day, reschedule the visit, trying, insofar as possible, to stay in the window. DO NOT COLLECT ANY DATA if the target child is not there. As described below, the child caregiver observations must be spread across 2 days; thus, if you collect data (e.g. caregiver interviews) on a day when the child is sick, this would put you in the position of visiting on 3 days, which should be avoided.

If the peer scheduled for the peer observation is absent, do not reschedule the visit. If you have permission for two peers, use the second one. If not, you may wish to return on a third day to do only the peer interaction procedure or it may have to be missing for this STUDY CHILD.

5. Number of Observers

Only one research assistant (RA) will visit each child-care facility, unless a second individual must accompany the RA for safety reasons (2) for a "live" reliability check or (3) for the Peer Observation. The observer can not be the person who was/will be the child's home visitor at 15, 24 or 36 months. Child-care and home visits must be independent. We strongly recommend that the same RA conduct both visits for a given child-care arrangement. When the 24 & 36 month CC arrangement is the same, we recommend that the same RA who collected the 24-month CC data also collect the 36-month CC data.

6. What to Bring

You should bring with you to the child-care visit the following:

- Two additional copies of the consent form -- one to leave and one to bring back signed;
- A copy of the parents' signed consent form in case the provider wants to see this;

- Multiple copies of all data forms. Remember to take: (1) extra copies of the questionnaires to the second visit in case caregivers have lost the ones you gave them at the first visit or in case the caregiver(s) you gave them to at the 1st visit are absent on your 2nd visit; and (2) another set of consent forms in case there are new caregivers;
- The Profile Self-Monitoring form (centers and family daycare homes only);
- For centers only: The Director's Telephone Interview (filled out);
- Clipboard, "observe-record" tape or timer (use the 15 month tape); several #2 pencils;
- Stamped addressed return envelope for caregiver to use in sending back any questionnaires not completed by the second visit;
- Child care ID Worksheet;
- On the first visit, Peer Information Worksheet for Child Care Providers, several Parent Permission packets to arrange the Peer Observation Procedure; and
- On the second visit, materials for conducting the peer observation (see Chapter 27, Section 2, II, A).

7. Arriving at the Center/Home and Getting Started

In a center, find your way to the Director's office. Chat with him/her about your visit. Get the Director's Questionnaire or the Short Form of Director's Questionnaire (as appropriate) and the Director's Background Information Questionnaire which he/she should have completed. If he/she has not, suggest that perhaps she could fill them out before you leave or go over it with him/her on the spot. If he/she has questions about the questionnaires, answer them. Check that the questionnaires are complete. Ask him/her to describe all of the caregivers who are likely to be observed interacting with the target child and record this information on the Child Care ID Worksheet. Be sure to ask about each one's relationship to the child and whether he/she is specifically assigned to the child. Ask the Director to take you or show you to the room where you will be observing the target child. When you meet the caregivers, make sure you have completed permission forms for each caregiver who will be with the child.

If you are going to conduct a peer observation on the second visit, you should discuss it with the director and the head caregiver at some point during the first child care visit.

If you will need to enlist the caregiver's help in order to identify and contact appropriate peers, you should be prepared to explain the procedure and to leave peer observation packets with the caregiver at the end of the first visit. (See Chapter 27, Section 2, III, B, Peer Observation Manual).

In a home, introduce yourself and spend some time chatting with the caregiver to establish rapport and allay any concerns the caregiver may have about the visit. Follow the same protocol as with center caregivers for handling the introduction of the peer observation procedure in settings where one will be done on the second visit.

8. Whom to Observe, Interview, and Ask to Complete Questionnaires

In many cases, the child will have only one caregiver. However, in some large family day care homes (group homes) and in centers, the child may be cared for by more than one caregiver. In these cases, you need to determine whom to observe.

Observations will be done noting which caregivers and other adults were in the room and which caregivers and adults interacted with the child during each observation interval. All the caregivers with whom the child interacts, including non-staff adults and caregivers under 18 years of age, will be observed during the Behavior Scales observations. Because the focus is on the child's total caregiving experience, we will note which caregiver interacted during an observation period, so we can link up the behavior of individual caregivers with their individual interview data. Also see Section III. G. a and b, ADULT AVAILABLE and ADULT INTERACTING.

When determining who to rate on the Qualitative Scales remember that the Qualitative Scales serve to document the quality of the child's caregiving experience. The general rule for determining who to rate is as follows: the Qualitative Scales are coded for caregivers who are involved with the target child for at least two of the four 10-minute segments in a 44 minute observation. If one caregiver is exclusively involved with the child, additional caregivers will not be coded on the Qualitatives, even if they are present throughout the observation. If no caregiver is ever involved, then all caregivers present (up to a maximum of 3) will be considered responsible and all will be coded. There will still be some judgement on what constitutes "involved", but it will clearly require some indication that the caregiver is supervising, directing, or responding to the child during a 10-minute segment. Also see Section III,G.1.d and 4.b.

When the child is involved with a "non-caregiver" during a majority of the observation time, then the Qualitative Scales are to be rated for that adult, for that observation period (as well as any caregivers that fit the above criteria). There will not be any other data collection done on these non-caregivers and they will not be assigned ID numbers. By the same reasoning, if the head teacher does not meet the "2 segments involved" or "no one involved" criteria, then the head teacher would NOT be rated on the Qualitatives for that observation period.

Up to a maximum of two of these same caregivers will be interviewed. All caregivers who are interviewed should be asked to fill out questionnaires as well. The two caregivers who are interviewed should be the following:

First, the caregiver who interacted with target child most during the two sets of observations conducted on Day 1. It is important to identify the caregiver who interacted the most with the target child, who may or may not be the caregiver who was in the room the most. In centers that assign specific caregivers to specific children, you might expect that it will be this caregiver, but again, it may not necessarily be this caregiver.

Second, the "lead" teacher in the class, if he/she interacted with the target child at all during the observation.

Third, if there is no "lead" teacher, the caregiver who interacted with the child second most during the observations.

Some family day care providers will have "helpers". These are often family members who do not work full-time in the home, and many will not consider themselves to be caregivers. For our purposes, what is important is whether they provide care to the target child 10 or more hours per week, during a typical week. In this case, they are caregivers to us. They need an ID number. The primary caregiver should get a REL code of 4 (since this really is a hierarchical arrangement -- it is clear who is in charge and who is primarily responsible), and the "helper" should get a REL code of 5.

These "helpers" who meet our 10 hour a week criteria are considered caregivers and should be given the questionnaires and interviews if they satisfy one of the three qualifications listed above. Their Ids should be indicated on the ORCE when they are observed.

Sometimes these "helpers" may be young. One site had a 16 year old helper in a family day care home. Again, as long as the 16-year old is there 10 hours or more per week, he/she gets an ID number and is treated as a regular caregiver.

If the same (two) caregivers with whom you left the questionnaires at visit 1 are not there to be interviewed at visit 2 (a situation you should try to avoid), give the second day's caregivers the questionnaires as well as interviewing them.

Sometimes a caregiver will be under 18-years of age. It is important that you include these caregivers too. This poses a problem for the consent forms. You should clarify procedures with your human subjects committee. (It may be necessary to get the minor caregiver's parents' consent - perhaps over the phone).

Ask one caregiver (preferably the caregiver who interacted the most with the Target Child) the Post Visit Interview Questions, and put this ID on the cover of this form (Form 11W). For the End of Visit Scales, rate up to three caregivers. Choose the 3 caregivers who interacted with the Target Child the most over the course of the entire visit. Put these Caregiver IDs in the white space on page 3 of the Post Visit Interview Booklet (Form 11W).

9. When Dad is the Care Provider (and Other Family Exceptions)

When the father is the care provider, the visit follows the same procedure as other home care visits, except that: (1) you use the Caregiver Interview home version for fathers; (2) you DO NOT give any father the "Taking Care of Young Children" Questionnaire or the "Parent-child Behaviors when Parent Leaves/Returns".

When care is provided by a sitter in the child's own home or in another informal home-based arrangement, follow the same procedure as for family daycare homes. This arrangement can occur when the grandmother is a provider or when a neighbor or friend cares for only the target child in the neighbor's home.

When care is provided in the child's own home by the mother and the mother is a child care provider, providing care for other, non-resident children at least 20+ hours a week, use the HOME INTERVIEW FOR MOTHERS WHO ARE CHILD CARE PROVIDERS; do not give the following questionnaires: Taking Care of Young Children, pick up and drop off, My Feelings, CBCL, and ASBI. Do administer Ideas About Raising Children (see III.F for table).

10. Assigning Child Care ID's.

Each child-care provider observed or the subject of a mother phone interview and center director should be assigned an identification number. It is essential that you assign IDs to all observable CC arrangements that are observed or on which we obtain data over the phone form a director or mother. This ID consists of 7 digits and is tied to both the research site and the relationship (REL) code. By the 36 months observation, many programs and providers will have already been observed previously. Before the visit, child care observers should check the master list to determine if any arrangement ID has already been assigned. This is a good time to check the accuracy of the ID number used at a previous assessment point. Check to see that each digit is correct. See page 55 for what to do if a caregiver already has an ID number from a previous visit. The first digit of each Provider and Director ID is the Site Code. The second digit is the Relationship Code. This code identifies the person responding to the interview/questionnaire or who was observed, and refers to the relationship of the respondent to the study child. Specifically REL should be coded as follows:

0 - Mother (in cases where the mother is a child-care provider and also takes care of the target -- her own -- child).

1 - Father (the father is the child-care provider)

2 - Grandparent (the grandparent is the child-care provider)

3 - Other Relative (another relative, including sibling, aunt, great-grandparent, is the child-care provider)

4 - Primary Child-Care Provider (a provider with supervisory responsibility for the target child's classroom; sometimes called a head or lead teacher. Use this code, as well, for the owners of large family day-care homes, sometimes called group homes, in which more than one caregiver is employed or when the care provider's husband, mother, sister or anyone else regularly provides care for target child more than 10 hours per week. All of these other providers are assigned a REL code of 5.)

5 - Support Child-Care Provider (a provider who also takes care of the target child but who is not the teacher-in-charge for the target child's classroom, sometimes called an assistant teacher or aide, or who is not the main child care provider in a home, sometimes called a helper.)

6 - Child-Care Provider (no hierarchical designation; use in instances where all classroom teachers are of equal status, e.g., all "teachers" or all "assistant teachers"; this is also to be used in all instances where there is only one provider, e.g., in a small family day care home or in-home arrangement, given that this provider is not the mother or another relative.

7 - Director (only in centers)

As you can see, if the child-care provider is related to the child, use the relative code. If the child-care provider is not related to the child, use codes 4, 5, 6, or 7. If the child has more than one provider who fits a single relationship code (e.g., two assistant teachers), they both get assigned the same REL code. What makes the ID unique is the last four digits, as described on page 56.

The third digit, the Assignment Code, indicates whether the provider is specifically assigned to the Target Child:

1 = The provider is specifically assigned to the target child. For example, if the mother leaves the child to be cared for by the great grandmother, but the great uncle is always home

and actively cares for the child as well, the great grandmother would be giver an assignment code of 1.

2 = The provider is not specifically assigned to the target child. For example, in the situation mentioned above the great uncle would be given an assignment code of 2.

3 = Only one provider (use in arrangement, such as father care or family day care home with no other available providers). Don't take the director's word about assignment, ask the provider.

The remaining digits in the Child-Care Provider ID (4 through 7) are the unique code for each provider, starting with 0001 and ending with 9999. Thus, the first assistant teacher who is observed/interviewed at the University of Virginia site would be assigned ID 6520001. The second assistant teacher, if applicable, would be assigned 6520002. This unique ID will be assigned after the second child care visit by the site coordinator in consultation with the child care data collector. Make sure that this final ID is written on ALL FORMS in the designated spaces.

The Director ID will serve as the Child Care ID number for center-based arrangements and the caregiver ID number will serve as the Child Care ID number for all other arrangements. In the case of large family day-care homes with more than one provider, the ID of the lead child-care provider will serve as the Child

Care ID. If a family or group home is co-owned and there is not a clear primary provider, randomly assign one of the providers IDs as the arrangement ID. In cases where the same provider and/or center is visited at least twice because 2 study children use the same arrangement, or because a child was in the same care arrangement at 6 and/or 15, and/or 24 months, use the same unique ID for both observations. (Remember, however, that both the relative and assignment codes may change between visits so always check the current circumstances for assigning those digits.) This is our only way of knowing that it is the same center/provider. The Site Coordinator will keep a confidential list that matches names and ID's (see Appendix: Final Care Provider ID's.)

If the center remains the same over 2 assessment points, but the director changes, complete the Director Change Form. If a provider has moved from one program to another, then that provider should keep the same final caregiver ID number.

During the visit, the provider IDs will be temporary (see below) and then finalized by the site coordinator or her designate after both visits to a given arrangement are completed. This will occur for visits to center-based and large family day care (often called "group homes") arrangements, in which multiple caregivers are observed, interviewed, and asked to complete questionnaires. Recall that, although a maximum of two caregivers are interviewed and asked to complete questionnaires, more than two caregivers may be observed, given the child-focus of this observation.

The "on-site" temporary ID's will be assigned using an ID worksheet (see below and Appendix), and then finalized by the site coordinator (or counterpart) after the second visit to the arrangement. BRING THE ID WORKSHEET TO THE CHILD CARE VISIT. Prior to assigning the final ID's, the site coordinator (or counterpart) should check the master list of provider names to determine if the provider or the arrangement has already been assigned a permanent ID. If the provider had been assigned an ID on an earlier visit (at 6 months or with another child) then the following procedure should be used:

1. The last 4 numbers of the ID always stay the same for a provider. This is the provider's unique ID.

2. The first number of the ID is the site code and will never change.

3. The second and third digits will change if the caregiver's position has changed.

SUMMARY

ASSIGNING CHILD CARE IDS

The identification number consists of 7 numbers and is tied to both the research site and the relationship (REL) code.

SITE CODE (First Digit)

REL CODE (Second Digit)

0 - Mother

1 - Father

2 - Grandparent

3 - Other relative

4 - Primary child-care provider

5 - Support child-care provider

6 - Child-care provider

7 - Director (only in centers)

ASSIGNMENT CODE (Third Digit)

1 - Specifically assigned to target child

2 - Not specifically assigned to target child

3 - Only one caregiver

UNIQUE CAREGIVER ID (4-7th Digits)

0001 - 9999

Keeping track of caregivers' final Ids as caregivers and children change programs is a formidable task. Sites may use either of two methods. Sites may maintain a file on each caregiver seen. Files should be labeled and alphabetized by caregiver name. The file should include the caregiver's name, unique ID # (the last 4 digits), place of care, address and phone number of place of care, any other information necessary for contacting the caregiver if another visit will take place. The file should be updated if the caregiver switches her place of care. Also, in the file should be a list of all study children who are in the caregiver's care. This list can be added to as subjects are added. Paired with each subject's ID # should be the complete caregiver (7 digit) ID used for that subject's visit.

A second approach is to use a master list of caregivers that includes this same information.

11. Using the Child Care ID Worksheet

Assigning child care provider IDs and keeping them straight across observations will pose a major challenge in child care centers, where the target child is likely to have multiple caretakers. The CHILDCARE ID WORKSHEET (see appendix Section VII, H.) is designed to facilitate this process and assure our ability to cross-walk from the observational data to the questionnaire and interview data.

AFTER FINAL ID'S ARE ASSIGNED, THESE ARE WRITTEN ON THE CHILD CARE DATA SENT TO THE DATA CENTER.

As suggested in the previous section, it is CRUCIAL that the RAs assign temporary caregiver ID numbers when they visit the center, given the high turnover rates among staff. Immediately prior to starting the observation, find out who is likely to be in the classroom (ask the lead teacher or director) and interacting with the target child. Assign each of these individuals a temporary ID number using the ID worksheet (see appendix). Of course, you may be told that only one caregiver will be seen, only to find that a second caregiver enters the classroom and interacts with the child. Assign this individual a temporary ID for "caregiver 2" and when your observation is completed, check on this caregiver's relationship to the child and fill this information in on the worksheet.

For each observation cycle, match your temporary ID to the actual caregivers that you observe. For example, if you observed 4 different caregivers during cycle one (1=A (Sally), 2=B (Jenny), 3=C (Feehah), and 4=D (Don)), then you observed 3 of them during cycle two (say A, B, & D) PLUS one new caregiver, you would record the following for cycle two: 1=A, 2=B, 3=E, 4=D. This will allow us to match caregiver 1 to caregiver 1, caregiver 2 to caregiver 3, and caregiver 4 to caregiver 4 across these 2 cycles. We will also know that caregiver 3 in cycle one is not the same person as caregiver 3 in cycle two.

Use the space for "Description" to record permanent cues to help you keep the caregivers straight, e.g. hair, size, first name, etc. Clothes are not good cues since they will likely change from visit 1 to visit 2.

After observing for the behavioral scales, you will record data for the qualitative ratings for no more than 3 caregivers. This is described in the section on the qualitative rating procedures. For the purposes of the worksheet, indicate, for each caregiver (1 through 8) whether you consider him/her in the qualitative ratings, and which caregivers (1, 2, 3...8) number he/she was given on the qualitative ratings.

The data sheet for the qualitative ratings indicates 8 caregivers, to make it easier to match from the behavior scales to the qualitatives. NOTE that you will only rate 3 of the 8. It may be caregivers 1, 2 and 3 (persons A, B, and C) or 1, 3 and 4 (persons A, C, and D), or any other combination.

At the end of each day, you will complete the Post Visit Interview and Rating of the Caregiving Environment (Form 11W). Ask one caregiver (preferably the caregiver who interacted the most with the target child) the Post Visit Interview Questions and put this ID on the cover of this form (Form 11W). For the End of Visit Scales, rate up to three caregivers. Choose the three who interacted with the target child the most over the course of the entire visit. Put these caregiver IDs in the white space on page 3 of the Post Visit Interview Booklet (Form 11W). Indicate on the worksheet using Cg1, 2, 3....8, which caregivers you rated, and which day it is (1 or 2). For example, caregiver 1 for the end-of-visit ratings, may be caregiver 1 (=A on chart below) from the behavioral scales, or it may be another caregiver. We need to match up these data, and so need you to match actual individuals on this worksheet.

We need to know which caregivers completed the questionnaires and the interviews. Remember that all caregivers who do the interviews also complete the questionnaires (max of 2). Put their temporary ID on the questionnaires themselves and then replace this with the final ID once you are back in your lab. Also, indicate on the worksheet which caregivers were given the questionnaires.

Finally, before you leave the center on the last day, make sure that you have assigned a REL and ASSIGN code to each caregiver. This may require speaking to the caregiver, e.g. "Are you specifically assigned to the target child?" Without this information, your site coordinator cannot assign a final ID.

Here is an example of a completed CHILDCARE ID WORKSHEET, using 2 observational cycles:

Observation Cycle #1

Behaviorals	TempID	FinalID	Desc	REL	ASSIGN	QUALS?	END-OF-VISIT?	INT/QUES?
Caregiver 1	A		short, red hair	4	2	Cg1	Cg1-Day1	yes
Caregiver 2	B		Curly black hair	5	1	Cg2	Cg2-Day1	yes
Caregiver 3	C		male, blond hair	5	2	Cg3		
Caregiver 4	D		long, red hair	5	2		Cg3-Day1	
Caregiver 5								
Caregiver 6								
Caregiver 7								
Caregiver 8								

Observational Cycle #2

Behaviorals	TempID	FinalID	Desc	REL	ASSIGN	QUALS?	END-OF-VISIT?	INT/QUES?
Caregiver 1	A		short,red hair	4	2	Cg1		
Caregiver 2	B		Curly black hair	5	1	Cg2		
Caregiver 3	E		Dark black glasses	5	2			
Caregiver 4	D		long, red hair	5	2	Cg4		
Caregiver 5								
Caregiver 6								
Caregiver 7								
Caregiver 7								

We now know that the qualitative ratings for cycle 1 considered caregivers A, B, and C and that the qualitative ratings for cycle 2 considered caregivers A, B, and D. We know that at the end of Day 1, the global ratings were completed for caregivers A, B, and D (in that order). And we know that caregivers A and B were given the questionnaires to complete and the actual questionnaires should be marked with "A" and "B" before they were given to these two individuals.

After all the data are collected, the Site Coordinator or her designate will take this information, assign final IDs, and use the final IDs to complete all of the SCANTRON face sheets for the ORCE, interviews, and questionnaires. Also, put the final IDs and names on the CONFIDENTIAL WORKSHEET (see appendix Section VII, I.) for assigning final IDs. DO NOT send the CONFIDENTIAL WORKSHEET used in assigning final IDs to the Data Center.

The caregiver ID Worksheet should also be taken along during family daycare visits so that the same procedure may be followed in setting where more than one caregiver meeting our criterion is present.

12. When to Use Center vs. Home Instruments

If an arrangement uses space that doubles as a residential home, then use the home assessment instruments and procedures. This will apply to most so-called group family day care homes, which often employ more than one caregiver and enroll 6-12 children, but operate in residential settings.

13. Overview of the Two-day Visits

At the first visit the emphasis will be on observation of both the target child and the setting. Caregivers will not be interviewed about themselves at the first visit, because having information about the caregiver's background, training, etc.

might bias observation of her behavior. Caregivers will be interviewed on Day 2 only, after all the required observations have been completed. You will need to be somewhat flexible, given special circumstances that will undoubtedly arise. You may suggest that the target child's nap time is a good time for the interview, but he/she may see things differently. EMPHASIZE that you need to complete the caregiver interview before you leave and try to establish at the beginning of your visit the optimal time to do it. Sometimes it may work out better to interview the caregiver before you have finished all required observation cycles -- because the child falls asleep, the caregiver has a break, etc. If you have to make a choice between interviewing the caregiver before the 4th (or even the 3rd) observation cycle and coming back to interview her at a third visit, do the interview before the observations. If you have a choice between interviewing the caregiver before the 4th observation cycle and coming back to interview or at a third visit, come back for a third visit or try to interview her by phone. Just be aware that you should not be influenced in your observation ratings by any information about the caregiver's background you have discovered in the interview. Caregiver training is not a guarantee of greater sensitivity, for example.

The peer observation procedure is planned to take place during the second child-care visit in all cases where an appropriate peer is available at the setting, unless you have made alternative arrangements with staff to do the peer observation during a separate visit. (See Chapter 27, Section 2, II. A., Getting Ready for the Peer Observation Procedure). A summary of the suggested order of the observation and interview procedures is as follows:

FOR CENTERS:

First visit

- Introductions, instructions, getting settled (10 minutes)
- First Profile Observation: 15 minutes to complete Safety/Health, Learning Environment, and Physical Environment subscales (recommended order of subscales)
- First 44 minute ORCE observation cycle: 30 minutes on Behavior Scales and 14 minutes on Qualitative Scales
- Second 44 minute observation cycle
- Second Profile Observation: 30 minutes to complete curriculum and interacting subscales (recommended order of subscales)
- Questionnaires -- explain and leave to pick up at second visit
- Profile respondent/documentation items completed :5 minutes
- Post Visit Interview and Rating of the Caregiving Environment questions for the one caregiver who interacted the most with the target child (3 minutes)
- End-of-visit rating scales for first visit (2 minutes)

Second visit

Third 44 minute ORCE observation cycle (DO NOT COMPLETE ALL OBSERVATIONS ON DAY 1; one MUST be done on Day 2).

Fourth 44-minute ORCE observation cycle

Interview with up to 2 caregivers including:

Child Caregiver Long or Short interview (15 minutes)

Peer Observation (must be after the fourth 44-min. observation cycle)

Pick up questionnaires

Post Visit Interview and Rating of the Caregiving Environment questions for the one caregiver who interacted most with the target child (3 minutes)

End of visit rating scales for second visit (2 minutes)

Leave payment and have recipient complete the receipt form.

FOR FAMILY DAY CARE HOMES:

First visit

Introductions, instructions, getting settled (10 minutes)

First Profile observation: 15 minutes for safety, Learning Environment, and Physical Environment Subscales (recommended order of subscales)

First 44-minute ORCE observation cycle: 30 minutes on Behavioral Scales and 14 minutes on Qualitative Scales

Second 44-minute ORCE observation cycle

Second Profile Observation: 30 minutes for curriculum and Interacting subscales (recommended order of subscales)

Caregiver Questionnaires -- leave to pick up at second visit

Profile respondent/documentation items completed: 5 minutes

Post Visit Interview and Rating of the Caregiving Environment for the one caregiver who interacted the most with the target child questions (3 minutes)

End-of-visit rating scales for first visit (2 minutes)

Second visit

Third 44-minute ORCE observation cycle (DO NOT COMPLETE ALL OBSERVATIONS ON DAY 1; one MUST be done on Day 2).

Fourth 44-minute ORCE observation cycle

Interview with up to 2 caregivers including:

Child Care HOME interview (45 minutes)

Appropriate Child Caregiver interview (15 minutes)

Peer observation (after the fourth 44-min observation cycle)

Pick up questionnaires

Post Visit Interview and Rating of the Caregiving Environment for one caregiver who interacted the most with target child questions (3 minutes)

End-of-visit rating scales for second visit (2 minutes)

Leave payment and have caregiver complete the receipt form.

FOR OTHER HOME SETTINGS

First Visit

Introductions, instructions, getting settled (10 minutes)

First 44-minute ORCE observation cycle: 30 minutes on Behavioral Scales and 14 minutes on Qualitative Scales

Second 44-minute ORCE observation cycle

Third 44-minute ORCE observation cycle

Caregiver Questionnaires -- leave to pick up a second visit

Post Visit Interview and Rating of the Caregiving Environment for the one caregiver who interacted the most with the target child questions (3 minutes)

End-of-visit rating scales for first visit (2 minutes)

Second Visit

Fourth 44-minute ORCE observation cycle

Interview with up to 2 caregivers including:

Child Care HOME Interview (45 minutes)

Appropriate Child Caregiver Interview (15 minutes)

Peer Observation

Pick up questionnaires

Post Visit Interview and Rating of the caregiving Environment for one caregiver who interacted the most with target child questions (3 minutes)

End-of-visit rating scales for second visit (2 minutes)

Leave payment and have caregiver complete the receipt form.

14. Minimum Data Collection Required

At least two visits and four observation cycles are required. A cycle is 30 minutes on the Behavioral Scales (15 of actual observing and 15 of recording) + 14 minutes on the

Qualitative Scales. The minimum length of a cycle will be 20 minutes (the 20 minutes will be spent doing the Behavioral Scales and the ratings for the Qualitative Scales will be based on this time). NEVER COMPLETE ALL FOUR OF THE OBSERVATION CYCLES ON THE FIRST DAY.

Interrupted Cycle. If one of your ORCE cycles is interrupted by a nap, or whatever, but the cast of characters (caregivers and children) and the setting remains the same when the child wakes up, you can resume the cycle where you left off. If, however, any of these factors has changed, then you must start a new cycle.

Incomplete Cycle. Any ORCE cycles of data collection which are not completed should be sent to the DCC with whatever data was collected on them. The complete cycles should not be renumbered leaving the incomplete cycle out.

Do the Peer Observation on Day 2 or Day 3. It must come after the fourth observation cycle. Do not do the peer observation before the fourth observation cycle because it could alter the child's behavior. Conduct it any time during the rest of the visit that fits the convenience of the setting and the schedule of the child and peer.

15. Feedback

If the caregiver asks for feedback, assure him/her that he/she will be sent a copy of the results when the Study is completed and that, due to confidentiality, we cannot release any information about individual children, families, or child-care programs.

Only general information should be given to caregivers. Emphasis should be on our wish to capture the child's experience in the setting and not on any desire to evaluate the quality or adequacy of the center, home, or caregiver. Emphasis should be on the "exploratory" (vs. evaluative) nature of the data collection: We don't know how children's experiences contribute to their development unless and until we collect information about those experiences.

If the parent asks for information about the child-care setting, most times the person talking to the parents will not have any information about the child-care setting because a different observer will be making these visits. Parents who ask, however, should be encouraged to observe in their own daycare sites, to talk to their caregivers about their concerns, etc. They should also be told that decisions about day care arrangements are personal ones, and that what makes one parent comfortable will not necessarily make another parent happy; hence our advice is not as important as the parents' personal observations and values.

16. Flexibility

Child-care environments are rarely consistent or predictable. This requires flexibility on the part of the research assistants. It is important that -- within the constraints of the prescribed order of observation/interview procedures -- you accommodate to the caregiver's (program's) needs and schedule, in addition to the child's schedule.

17. Multiple Study Children in Same Arrangement

As part of the 36-month observations in those cases in which one study child attends the same child care arrangement as another study child, the following procedures should be followed:

1. It is desirable to have different child care observers collect the data for the children.

2. A complete set of caregiver-child interaction (ORCE) data should be collected for all children, i.e., four 44-minute ORCE observations should be made for all Study children.

3. Please use the following guide depending on the situation encountered.

4. The four months should be calculated from the second child care visit to the second child care visit.

5. In child care arrangements in which there are more than 2 study children, calculate the 4 months from the time the first child was visited.

< 4 months after initial visit within the 36-month assessment period and NO staff turnover:

CENTER	FDC
Director Telephone Interview_	
Center Version--	Home Version--
Caregiver Interview (Short Form)	Caregiver Interview (Short Form)
*6/7 Caregiver Questionnaires	same
* When Parent Leaves	
* When Parent Returns	
* Taking Care of Young Children	
* ASBI	
* CBCL	
* My Feelings	
	HOME

< 4 months....................and staff turnover

CENTER	FDC
Director Telephone Interview	
Director Questionnaire (New director-Long Form; old director-none)	
Center Director Background Information Ques (New director only!)	
Center Version-	Home Version
Caregiver Interview (New caregiver-Long Form; same caregiver-Short Form)	Caregiver Interview (New-caregiver-Long Form; same caregiver-Short Form)
*7/7 Caregiver Questionnaires (for each new caregiver)	same
* When Parent Leaves	
* When Parent Returns	
* Taking Care of Young Children	
* ASBI	
* CBCL	
* My Feelings	
* Ideas about Raising Children	
Profile	Profile (formal FDC homes only)
	HOME

4 months-11 months, 31 days after initial visit within the 36-month assessment period and NO staff turnover:

CENTER	FDC
Director Telephone Interview	
Director Questionnaire (Short Form)	
Center Director Backgrd Info Quest.	
Center Version	Home Version
Caregiver Interview (Short Form)	Caregiver Interview (Short Form)
6/7 Caregiver Questionnaires	same
* When Parent Leaves	
* When Parent Returns	
* Taking Care of Young Children	
* ASBI	
* CBCL	
* My Feelings	
	HOME

4 months-11 months, 31 days....................and staff turnover

CENTER	FDC
Director Telephone Interview	_
Director Questionnaire	-
(New director-Long Form; same director-Short)	-
Center Director Background Information Ques (for new or old director)	
Center Version- Caregiver Interview (New caregiver-Long Form same caregiver-Short Form)	Home Version- Caregiver Interview (New Caregiver-Long Form same caregiver-Short From)
7/7 Caregiver Questionnaires (for each new caregiver..see above list)	same
6/7 Caregiver Questionnaires (for same caregiver......see above list)	same
Profile	Profile (formal FDC homes only) HOME

18. Taking Leave

Before you leave, thank and say goodbye to the caregivers and reconfirm the next visit. At centers say goodbye to the Director as well, and pick up the Director's Questionnaire, if you haven't already. At the second visit, pick up the caregiver's questionnaires and leave the payment with the appropriate person.

B. General Interview Procedures for Caregivers

This section describes the procedure for obtaining the interview data from the caregiver(s).

At the end of the second visit, you will do the caregiver interview(s). Caregiver interviews should be done after the observations, at the caregiver's convenience. You may suggest that the target child's nap time is a good time for the interview, but he/she may see things differently. EMPHASIZE that you need to complete the interview before you leave.

Reread the section on assigning caregiver ID's (see Section III.A.8, Assigning Child Care ID's, above) and be sure to match the ID's used during the observations with the ID's of the caregivers who are interviewed.

The interview is structured predominantly as a "guided" interview. Read the question to the caregiver (he/she will ideally be sitting where he/she can read along with you, e.g. side-by-side at a table) and record his/her answer. In some cases, there are several response choices. You should still record the answer(s), but in these cases, you do not need to read every response choice unless the caregiver wants you to. Rather, move the interview form in front of the caregiver and suggest that he/she read the responses and then indicate his/her answer(s) for you to mark.

The best circumstance under which to administer the interview is one in which the caregiver is not simultaneously responsible for supervising children. In most cases, however, this will be impossible. Thus, you will need to become accustomed to frequent interruptions. You will want to sit beside the caregiver so that he/she can read along with you. You (and he/she) will undoubtedly be tempted to simply let the caregiver complete the interview as a questionnaire. Our experience tells us that this produces both incomplete and unreliable data. Although most of the interview items are very straightforward, a busy caregiver will always be tempted to read and answer items quickly and, perhaps, not as carefully as possible. You will also find that there will be more questions than you might anticipate, given the individual circumstances that frequently arise (e.g., "*I haven't had any training in the last 12 months, but I spent the previous year taking a college course in child development -- can't I count that?*").

There are quite a few SKIP patterns in the interviews. Be sure to have these patterns well memorized, along with the information in the manuals that accompany each interview form, so that the interview will go as smoothly as possible.

In administering the interview, please listen to what the caregiver says and remember it from one question to the next. If he/she has already (inadvertently) answered a question in responding to an earlier one, when you come to the later question pose it in a confirmatory way (*"And you said that..."*), not as if you hadn't heard her the first time. Ditto if you see her doing something; don't act as if you didn't notice. Say *"And I noticed... do you always/ do you usually"* -- or whatever is appropriate. Use common sense, tact; be sensitive, intelligent. Also, please use language that is appropriate for the individual caregiver: if he/she considers herself a "babysitter," don't refer to her as a "caregiver" or "care provider"; if the father is not married to the child's mother don't refer to her as "your wife," and so on.

C. Which Interviews to Use When

There are multiple versions of the interview.

1. The 4 Versions of the Director Interviews

* Director Telephone Interview -- There is only one version of this. Always complete this interview even if one has been done within the past 4 months.

* Director Questionnaire (Long Form) -- Use for directors who have not been interviewed before and for directors who were interviewed for the target child at 24 months.

* Director Questionnaire (Short Form) -- Use the Short Form if the director was interviewed for another study child within the past 4-12 months.

* Center Director Background Information Questionnaire -- There is only one version. Always use this interview at each

assessment period. In the case of multiple study children, use this questionnaire again if the director completed it for another study child at least 4 months earlier.

2. The 6 versions of the Caregiver Interview

* Center Version (LONG FORM) -- Use for all caregivers, including mothers, in center-based care who were not seen at 24 months. Always use the Long Form if the caregiver has changed her/his place of employment, regardless of when the last interview took place.

* Center Version (SHORT FORM) -- Use the SHORT FORM 1.) if the caregiver was interviewed for the target child at 24 months or 2.) if the caregiver was interviewed for another child in the study within 12 months. Before you go to the center, review the responses the director/caregivers gave on the prior interviews so you will know what the earlier situation was (re caregiver training, class size, etc).

* Home Version (LONG FORM) -- Use for all home-based caregivers (including family day-care providers, nannies, grandmothers, child care providers and their paid or unpaid helpers who provide regular care at least 10 hrs/week), who have not been interviewed at 24 months. Always use the Long Form if the caregiver has changed her/his place of employment, regardless of when the last interview took place. This form is also used in the situation where a mother brings her baby to work and someone looks after him/her (not a work-site center). Some of the questions on this form have to be stretched to be appropriate for a "helper." You must take into account the primary care provider's responses. Use the following

guidelines for interviewing a helper: In general, questions that provide new information should be answered. Those that ask for information about the program (policies, age of the children, etc.) should be skipped. Ask the following questions:

Section A (The Child) Answer A1-A3, A5-A8,

Section B (The Wages) answer B1, B2 (answer this question the way it is written. We will miss some "in trade" agreements between the assistant and the provider. For example, we had one assistant who worked for free in return for room and board. We also had one assistant who brought her child to day care for free as part of her pay.) Answer B6-B8.

Section C (Other children) (D,E,F,G,H) Skip entire section.

Section I (Caregiver's Background) Entire section is to be answered.

Section J (Child Care Experience) Answer J1-J5 and J8-J12.

Section K Educational Background) Entire section is to be answered.

Section L (Reasons for Providing Child Care) Entire section is to be answered.

Section M (Future Plans) Entire section to be answered.

* Home Version (SHORT FORM) -- Use the SHORT FORM 1.) if the caregiver was interviewed for the target child at 24 months or 2.) if the caregiver was interviewed for another study child within 12 months. Before you go to the home, review the responses the caregiver

gave on the prior interview so you will know what the earlier situation was (re: caregiver's training, etc.)

- Home Version for Fathers (Long Form) -- Use for all arrangements in which the father is the provider. Always use the Long Form.

- Home Version For Mothers Who Are Child Care Providers (Long Form) -- Use for all arrangements in which the mother of the target child also takes care of other children for 20 or more hours per week. Always use the Long Form.

3. Differentiating Centers From Family Day-care Home

With respect to group family day care homes, we will use the measures for home-based child care when the care occurs in space that is also used as a residential home. We will use the measures for center-based care when the care occurs in space that is not also used as a residential home (even if the building looks like a home). If there are two providers in the family day care home, collect all relevant data (observations, interviews, questionnaires) for both of them.

D. Specifics on Director Telephone Interview and Questionnaire

1. Director Telephone Interview (Form 11A)

This is a straightforward interview, which consists of 8 questions. With respect to questions 6, 7 and 8:

- Question 6, page 4: Please get the total number of children enrolled in the room. There may be some cases where, because of part-time children, the maximum children in the room at one time is less than the total number of children enrolled in the room, e.g., 9 children enrolled, but only 7 in the room at one time due to part-time children. But, please code "9" in this case. We get the maximum number of children at one time in question 8.

- Question 7, page 4: Code the ages of all children enrolled in the room (see Question 6, ORCE: General Procedures, Addendum).

- Question 8: This is where you code the maximum number of children at any one time.

2. Director Questionnaires (Long-Form 11D Short-Form 11U)

Because of the important information dealing with profit/non-profit status, credentialing, and staff, the Long Form, 11D, must be given at least once every assessment period regardless of how many study children may be in care throughout the 24-month assessment period. The four month time rule for use of the Short Form, 11U, applies only within assessment periods. This questionnaire asks for information about the staff, the number of children and general information about the center.

Be sure to explain on the phone how to do the questionnaire as it will be mailed to the director. If not completed when you get to the center, go over it with the director. If he/she has any questions about the questionnaire, here are some aides to answering them. Remind the director to complete the questionnaire using a soft pencil and tell her, if in doubt, to leave it until she can discuss it with you.

Information on specific questions follows:

Question A3. If a program simply rents space from a church (church-housed), they are not church-sponsored. Sponsorship implies that the church (or other entity) effectively owns/runs or pays someone else to run (as is sometimes the case in corporate programs) the child-care center. If a center is in a federal or state building and set up for government employees, it is sponsored by a "corporation/business/hospital."

Question A6. Full-day care means at least 6 hours a day. Programs that are open for 6 hours a day, but only allow children to be enrolled for one of two 3-hour sessions are part-day programs. Night care means care that accommodates shift work, e.g., past 7 pm. Sick care means care beyond the usual adjustments that are made for mildly ill children. A good indicator is a separate room where sick children can be isolated with a caregiver assigned to this room.

Question B3. This refers to the maximum number of children there on any given day, NOT the center's licensed capacity. If a center has 40 children enrolled, but has a licensed capacity for 50 children, code "40".

Question B5. Does not include cognitively slow children, unless specifically determined (by teacher, director, or other) to be handicapped or learning disabled.

Questions C1-C3. If the center uses different titles, use the following definitions and match staff to functional roles: Assistant teachers and aides: Provide care under the supervision of a more senior/experienced member of the staff. Teachers and teacher-directors: The lead staff person in a classroom, or in a cluster of classrooms. Sometimes called head or lead teachers. Teacher-directors combine administrative and caregiving responsibilities on a regular basis. Administrative Directors: Exclusively an administrative staff member, although may sometimes substitute in the classroom if short-staffed.

3. Center/Director - Background Information Questionnaire (Form 11T)

This questionnaire is also mailed to the Director before the child care visits. Remember to explain on the phone how to do the questionnaire. If not completed when you get to the center, go over it with the director.

This questionnaire asks for information about the Director's background, including training and education. It also asks for some information about the Program's funding. Because some of the questions are of a personal nature (e.g. salary), you should assure directors that their responses will be kept confidential.

E. Specifics on Child Caregiver Interview

1. Center Version-Long Form (Form 11F)

Information on specific questions follows:

Question A3. If his/her schedule varies day by day, get a weekly average and divide by the total number of days/week he/she provides child care to CHILD. Remember this is not necessarily the number of hours the child is at the center.

Question A4. An individual assignment must be made as explicit policy. Individual assignment means that a caregiver is assigned as primarily responsible for specific individual children in the group. For example, you may have a group of 16 children with 3 caregivers. In many cases all of the caregivers are responsible for all of the children. However, some centers follow a policy whereby each caregiver is assigned to 1/3 (a sub-group) of the children as her primary charges. Sometimes these subgroups may even split off into separate small groups with their one primary caregiver for certain activities but this is not essential to the definition of individual assignment. Therefore, in cases where caregivers are assigned to subgroups give the number in the group or if individual assignments are not made give the total number.

Question A5. Do not count the cook, administrative director, etc., in a center if they do not regularly provide child care beyond their primary responsibilities as cook, administrator.

Question B5. For any items for which response code is in years and the caregiver's response is less than 1 year, code as 00 (e.g., length of time working in center.)

Question B4. If the caregiver has a joint custody arrangement count the children involved as "own children."

Question B6. Some children will have multiple, simultaneous arrangements over the course of a day or week. Let the caregiver circle all arrangements that are used for more than 10 hours a week.

Question C1. Write verbatim what the caregiver tells you.

Question C4. What is needed here is the hourly wage before taxes.

Question C5. If caregiver has worked less than 1 year, code the number of months she is planning to work.

Question C9. "In the field" includes activities, such as consulting, training, or working for a child-care resource and referral agency, that are directly tied to the early childhood and child-care fields, as well as direct caregiving.

Question C13. Err in the direction of indicating "yes" if he/she names an organization that you are not familiar with.

Question E1. A high school diploma plus one college course is coded as "14". A high school diploma plus 4 college courses is also coded as "14".

Questions E3 & E4. If he/she is unaware of state certifications, then he/she does not have one. Not all states offer all of these certificates/credentials. Any certificates that are issued by the state and that are used to qualify a person as a caregiver of young children should be coded as "state certification in ECE". For example, the Massachusetts Office for Children issues Office for Children certificates which specify whether a caregiver meets the state criteria as a "teacher" or a "lead teacher". These count as "state certification in ECE".

Question E5. Err in the direction of indicating "yes" with respect to course work and training.

Question E6.

1. High school (while caregiver was a student in high school)
2. Vocational school (child care training, nannying, teacher's aide)

3. College (courses or major in child development, early education)
4. Graduate school (courses in child development, early education)
5. Adult education (at community college, university, or high school; credit or noncredit; through extension)
6. Conference or workshop (one or more conferences)
7. In-service training (offered at preschool)
8. Correspondence or television course
9. Parent education classes

Question E9. Training that is required by the state or by an employer for purposes of advancing from a teacher to a lead teacher (as in Massachusetts) should be coded as "yes", training that is required.

Question E10. If he/she cannot remember hours, get a best guess.

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For horizontal numbers 1  2  3  4 the top row is tens,
                       1  2  3  4 the bottom row is ones.
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Question E12. Do not ask at 36 months.

Question E13. "The director lets me do it" is not considered "support."

Question F2. Do not read this out loud if there is any chance you may be over-heard.

2. Home Version - Long Form (Form 11J)

Some of the material presented in section A on the center version applies here as well, e.g., how to code the age of the caregiver's child.

Information on additional specific questions in the home version follows.

Question A3. Use 2 hour differential as the rule of thumb for whether a schedule varies from day to day. Therefore if one day cg. does care from 9-12 and one day 9-3 code that the schedule varies from day to day.

Question A9. The skip should say N (go to question A11).

Question A10. Code in order of hierarchy - top to bottom. For example, grandfather could be 4 or 7 - code 4.

Question B2. Count free rent, parents take cg. shopping, parents make dinner for cg. etc. as "in trade."

Questions B4 and B5. Use the target child's rate if rates vary for different children. If a provider charges a set amount, regardless of whether a child comes part- or full-time then code the same rate for both questions, e.g., if he/she charges $35 per day regardless of hours, then both questions are answered with 5 x $35 = $175. If a provider charges $4.00 per hour, then full-time is 40 X $4.00 = $160 and part-time is 20 X $4.00 = $80. If the number of PT hours varies for different children, just get the hourly rate and multiply by 40 for the FT, weekly rate and by 20 for the PT, weekly rate.

Question D3. Some caregivers may not consider their nieces, nephews as children in their care. Rely on your own observations of children who are there and confirm by asking caregiver directly: "I can't help noticing Jimmy and Johnny. Who are they? Do they come here regularly?" Other caregiver's may consider live-in grandchildren as their "own" children. But for our purposes these are "other children".

Question D16. This must be more than once every 2 months - for example when parent travels etc.

Question D20. Write down what the cg. says even if this contradicts observations.

Question D24. Other caregivers may consider live-in grandchildren as their "own children". But, for our purposes, these are "other children". (Note this refers to parallel questions - see E1.)

Question D25. Please include grown children of the provider (his/her own children), but not spouses or children of these children, or children of the provider's relatives. (Note this refers to parallel questions - see E2.)

Question D26. If there is a live-in, daughter-in-law, she does not get coded as "grown children living at home". These include only children of the caregiver. (Note this refers to parallel questions - see E3.)

Questions D27 and D28. These questions refer only to children of the caregiver that are under 16 years of age.

Question D28. This is for the time that cg. is providing care for other children.

Question E6-E13. These questions refer to other children besides Target Child and caregivers own children.

Question I2. You may read this list and/or let them look at the list.

Questions J2-J4. Questions J2 and J3 refer to paid and unpaid child care. NOTE THAT THE INTERVIEW FORM ONLY INDICATES PAID CARE. Please include unpaid, as well.

Question J6. If the caregiver does not know what these terms mean, then he/she is NOT licensed or registered.

Questions J8, J9 and J10. Include nanny agencies as long as they provide the kinds of support that are asked about.

Question K10. For a college course only count classroom time not study time.

Question L2. Please code "N" for Not a reason for items that do not apply to the provider, for example the item "to see my grandchild/niece/nephew grow up" should be coded N for unrelated providers.

Question L3. Please code "1 - Not at all important" for items that do not apply, such as "to give the child a home away from home" in cases of in-home care.

Question M1. If caregiver is just taking care of Target Child until Target Child is in school and does not have any places to take care of any other children code as short term job.

3. Home Version - Short Form (Form 11I)

Question J5. DO NOT ASK this question.

Question J6. This question pertains to the period since you last say the provider. If the provider had a license at a previous time period and there hasn't been a change code "no". If the provider has had a licensed renewed code "yes".

Question J11 Ignore the skip pattern.

Question J13 Always ask this question.

4. Home Version for Partners (Form 11G)

This version follows closely the Home version. It is written so that the language is appropriate for fathers and partners. When referring to the child's mother use whatever term seems most appropriate (e.g. your wife or your partner or target child's mother or Mary).

Form 11G. Change "Fathers" to "Partners"

Start by telling them that this interview does not ask about his/her employment or education because we have that information from the Mother's interview.

Throughout the interview, "child care" is defined as the time when the partner is caring for the Target Child while the mother is working.

Questions D1 and D2 on page 9 should be skipped at 24 months.

5. Home Version for Mothers Who are Child Care Providers (Form 11X)

In general, it would be helpful at the outset of the interview to explain to the mother that you are interested in her role as a child-care provider for other children as well as target child.

All of these questions refer to times when the mother is caring for her child at the same time as other children.

Questions B1-B3. These questions include all children (other then TC). Can include TC's siblings.

Questions B4-B8. These questions only include other children - this does not include TC or TC's siblings.

F. Child Care Provider Packet, Child Behavior Checklist, and Adaptive Social Behavior Inventory (Form 11K)

The child care provider packet consists of 7 questionnaires: Parent Leaves, Parent Returns, Ideas About Raising Children, Taking Care of Children, My Feelings, The Child Behavior Checklist, The Adaptive Social Behavior Inventory. Not all questionnaires will be completed by all types of childcare providers - see following guide.

Parent Leaves	X	X	X	O	O
Parent Returns	X	X	X	O	O
Ideas	X	X	X	X	X
Taking Care	X	X	X	O	O
My Feelings	X	X	X	X	O
CBCL	X	X	X	X	O
ASBI	X	X	X	X	O

X - YES

0 - NO

Before giving the questionnaires to the caregiver(s), remember to complete the ID information for the caregiver and the CHILD. Write in the CHILD 's name on the instruction page.

The child-care visitor will leave the questionnaires with the caregiver(s) -- maximum of 2 -- at the end of the first visit. These will be collected and reviewed at the end of the second visit. If the caregivers do not have the questionnaires finished at the end of the second visit, offer to pick them up at a later date or leave a stamped/addressed envelope with the caregiver for him/her to mail the questionnaires to you. YOU WILL NEED TO FOLLOW-UP ON THIS TO ASSURE THAT YOU GET ALL THE QUESTIONNAIRES.

It is possible that some caregivers will not want to complete the questionnaires on their own. Our goal is to get the best data possible, so in these cases, work through the questionnaires -- one by one -- with the caregiver.

We strongly recommend that, as part of introducing each questionnaire, you have the caregiver read and complete the first item for each form. This will assure that he/she knows how to use the SCANTRON forms and understands the response choices. This will, of course, produce better data.

Introducing the questionnaires: A sample script:

"Here are the questionnaires I told you about. Please fill them out the best that you can. There are some items that refer to CHILD and some items about child care and child reading in general."

"Four of the questionnaires ask you about (CHILD) and I have filled in (his/her) name to remind you of this." [GO OVER WHEN "PARENT LEAVES AND RETURNS", "CBCL" & "ASBI"] If parents alternate, ask the caregiver to respond based on the most typical/common

situation. If the two parents always come by together or really alternate equally, then ask the caregiver to complete this form for the mother, since this will be most comparable with the other target children (sorry dads). *"The other three questionnaires ask about your own feelings"* [GO OVER THE "IDEAS ABOUT RAISING CHILDREN", "TAKING CARE OF YOUNG CHILDREN", and "MY FEELINGS" QUESTIONNAIRES].

"If you feel a question does not apply to yourself or to CHILD please fill in N/A (Not applicable) or make a short note. Do not leave any questions blank because we will think that you overlooked that item. Please do not write CHILD's name or your name on any of the forms. They are identified by ID number.

Please complete the questionnaires by yourself. We are interested in your own thoughts. Obviously, there are no right or wrong answers. Let me know if you have any trouble. I will answer any questions you may have at the end of my next visit. I will need to take the forms with me at that time (remind her of the exact date).

Thanks again!"

G. ORCE Procedures

The Observational Ratings of the Caregiving Environment (ORCE) is an instrument that examines the characteristics of the child's experiences in child care settings in two different ways: by observing the frequency of caregiving behaviors and by rating the quality of caregivers' behavior.

The behavior (frequency) scales record the occurrence of key behaviors in the following areas: positive affect, language-focused interaction, stimulation of development, behavior management, child's activity, and child's interaction with other children and child's autonomy. The qualitative (rating) scales record the caregiver's and child's behavior in the following areas: caregiver's sensitivity, intrusiveness, detachment, stimulation, and affect, and child's mood, engagement with caregiver, activity level, sociability, and attention. At the end of each day of observation, global rating scales are completed.

The procedure during an observation cycle is the following:

- 10 minutes of observation using the behavior scales (following a schedule of 30 seconds of "observe" time; 30 seconds of "record" time), indicating which caregiver(s) were available and which interacted with the child during each observation interval.
- 2 minutes of note taking for qualitative ratings based on the 5 minutes of observe time during the preceding 10-minute observation period
- 10 minutes of observation using the behavior scales
- 2 minutes of note taking for qualitative ratings based on the 5 minutes of observe time during the preceding 10-minute observation period
- 10 minutes of observation using the behavior scales
- 10 minutes of observation and note taking for the qualitative ratings that incorporate the 5 minutes of observe time during the preceding 10-minute observation period and the current 10 minutes
- completion of the qualitative ratings

RECORDING TIMES

Several forms require you to know how to record time on a 24-hour clock. This eliminates the use of am and pm. The 24-hour clock starts at 1 second past midnight with 0001 and runs to midnight, which is 2400. Here are some examples:

9:00 am = 0900
12:00 noon = 1200
2:00 pm = 1400
8:00 pm = 2000
10:30 pm = 2230

Use the 24-hour clock on the ORCE to indicate start and stop times. The start and stop times for the 44-minute observation periods are recorded on the first and last page of the ORCE form.

1. Conducting the ORCE at a Center

a. Before you start

Based on your interview with the director, you will know who the child's caregivers are, and whether they are specifically assigned to the Target Child. Mark this down on the Child Care ID Worksheet and the ORCE form so that you can confirm this once in the room. Also, find out the child's departure time and nap time for the day so you can plan how many observation cycles you can do. You will need to keep updating the ID information through-out your observations - keep the ID worksheet with you at all times.

b. Entering the room

The director will usually introduce you to the caregiver once you enter the room, but if not, be sure to identify yourself. Continue with the following script:

"As you know, I will be observing CHILD today. I want to see what a typical morning is like for him/her. I want to see how he/she acts around the other people in the room and how he/she pays attention to the things in the room. I want to find out what kinds of experiences he/she usually has. For the observations to be accurate, it is important that everyone act as naturally as possible and just do what they would be doing if I weren't here. I know this is easier said than done, but try to do what you would normally do. The purpose of these observations is really just to find out how children spend their time in child care. I will be following CHILD's activities, and I may, therefore, need to go in and out of the room. I'll try not to be disruptive. If you just ignore me, I hope that the children will too."

"Now I just need to make sure that I have everyone's names and positions straight." (Complete the information about caregivers at the top of the Caregiver ID Worksheet.)

"Is (caregiver's name) (child's name)'s primary caregiver?

Is ______the lead/head teacher/caregiver for the group?

Who besides _______ and ______ has responsibility for (child)?

If there are any other adults present, who are they?"

Make sure that you know the names of the caregivers whom you will be observing (up to a maximum of eight). Try to keep your conversation with the adults and your interaction with the children to a minimum. Ask if there is a particular spot where you can sit or stand. Look for a place that is as "out of the way" as possible, and yet provides a good view of the classroom, so there will be as little need as possible to move to follow child or caregiver.

Allow 10 minutes before you begin the observation. That will allow time for the room to resume its normal routine. It will give you and the children time to "settle in." At this time children may come over to you and try to get your attention by bringing a toy or by talking. Your job is to be as neutral as possible. This means not rebuffing the child, but not being overly encouraging. It is a fine line and not an easy task, but you will find your own way that is comfortable.

c. Overview of Behavior Scales

You will be observing and recording the behavior of the target child and of any caregiver's directed toward that child. Once you begin the observation period, focus on the target child. If the child leaves the room, follow her/him. If the group goes outside, accompany them. During this observation try (as impossible as it seems) not to let the target child know that she/he is being observed. This means looking at the group and avoiding eye contact with the child. As they occur, make mental note of behaviors that you know are on the checklist. Keep your attention on what is happening to the child during the "observe" period. If you are afraid you will forget some behavior that occurs, you may record it during the observe period as long as you do not miss any other behaviors that occur while you are glancing down at the record form.

Use the "record" periods to check systematically through the list of behaviors from top to bottom to make sure you have noted everything that happened. You will have 30 seconds to record your observations for the preceding half-minute. Accuracy is critical. For most of the scales, either the behavior occurred (mark it), or it did not (leave it blank). Even if the behavior occurred more than once in the interval, mark it just once. Each behavior should be coded only once in any category. A category may be left blank if no relevant behaviors occurred during the 30-second observation interval. (See page 102 for guidelines for Behavioral Scales for detailed definition of the items).

d. Overview of Qualitative Scales

For the Qualitative Scales, focus explicitly on the dimensions of caregiver and child behavior tapped by these scales. Be aware of all the caregivers who interact with the target child.

When determining who to rate on the Qualitative Scales remember that the Qualitative Scales serve to document the quality of the child's caregiving experience. The general rule for determining who to rate is as follows: the Qualitative Scales are coded for caregivers who are involved with the target child for at least two of the four 10-minute segments in a 44 minute observation. If one caregiver is exclusively involved with the child, additional caregivers will not be coded on the Qualitatives, even if they are present throughout the observation. If no caregiver is ever involved, then all caregivers present (up to a maximum of 3) will be considered responsible and all will be coded. There will still be some judgement on what constitutes "involved", but it will clearly require some indication that the caregiver is supervising, directing, or responding to the child during a 10-minute segment.

When the child is involved with a "non-caregiver" during a majority of the observation time, then the Qualitative Scales are to be rated for that adult, for that observation period (as well as any caregivers that fit the above criteria). There will not be any other data collection done on these non-caregivers and they will not be assigned ID numbers. By the same reasoning, if the head teacher does not meet the "2 segments involved" or "no one involved" criteria, then the head teacher would NOT be rated on the Qualitatives for that observation period.

Each set of qualitative ratings is to be based on a 44 minute cycle, of which 25 minutes are actual observation. During the first 34 minutes, the observer completes the Behavioral Scales and make notes for the qualitative ratings in the two 2-minute breaks. During the next 10 minutes, the observer should focus explicitly and solely on the qualitative ratings. To help observers remain on task during this time, they should take longhand notes or make preliminary ratings of caregiver or child behaviors as they relate to each scale.

In the definitions of each scale, we have avoided applying absolute frequencies of occurrence for assigning ratings. On occasion, raters will not be able to observe for the full 44 minutes. Also, frequencies may be dependent on specific activities in the child care setting. Consequently, in assigning ratings, you should use a two-step process. The first step is to ask, Is this dimension "characteristic" (a rating of 4 or 3) or "not at all characteristic" (a rating of 2 or 1) of the person being rated? Once this decision is made, then determine if the dimension is "sort of" characteristic or "very much" the case.

Ratings for most of these scales should be based on both the quality and quantity of behavior. Thus, evaluations should be made taking into account the quality of the observed behaviors in relation to the proportion of the time they were observed. (See Page 124, 5. 24-/36-month Qualitative Ratings for definitions of the items).

2. Conducting the ORCE at a Home

The ORCE procedures will be the same in home settings (child's own home, sitter's home, family daycare). However, your experience may be different. Although the setting may seem more informal, it is important for you to remember your role of objective observer and try not to be drawn into the activities of the environment. In addition, there may be more opportunity for informal conversation. By emphasizing to the caregiver that you want him/her to act as naturally as possible and to pretend that you are not even there, you are letting the caregiver know that you need to focus your full attention on what is happening in the setting.

Basically, you will follow the same sequence as in the center except that there will usually not be multiple caregivers.

Before you begin observing, when you first get to the home, spend a little time (not more than 10-15 minutes) chatting with the provider as an introduction and warm up. Caregivers may be nervous during this procedure, and so may you. You should spend a little time at the beginning just getting acquainted with the caregiver. The conversation might be about common or mundane things that any two persons might talk about. This will allow you to get some sense of who lives in the house and what their roles are in the family. Many times there will be another child present at the time of the interview, and it may be necessary to devote some attention to that child as well as to the key child. The general tone of the interview should be that of two friendly people, who like to talk about children, sitting down together and doing exactly that. This warm-up period offers a good opportunity to say something nice about the child (refer to the child's appearance or behavior, whatever comes easily to you and can be done honestly). Not only will the compliment help break the ice, but observation of the caregiver's response may enable you to score an item on the H.o.M.E. Inventory.

After the first ORCE subcycle (10 minutes) and the completion of the preliminary qualitative ratings, pause the audiotape while you tell the caregiver that this is what you will be doing for the next couple of hours. Ask him/her if he/she did anything different because you were there (didn't leave the room, didn't play with the child, etc). If she says she did, encourage her not to, but to continue business as usual as if you weren't there. Then begin the audiotape again to begin the next observe cycle.

3. Observer's Interaction with Caregivers

Whether at a home or a center, the observer should make every effort to put the caregiver(s) at ease (smiling, accepting a coffee and a chat at the end of the observation, etc.). You are a person, not a video camera (despite the fact that your observation record should be a accurate as a camera's). You have feelings, reactions, good sense and judgment that should not be left behind at the door. You should make your role as observer clear to the caregiver; you are there to watch, not to intervene (or babysit). We suggest that you state explicitly that "I am not allowed to be left alone with the children." The caregiver should behave as he/she would if you were not present. Thus, in arrangements with only one provider, the provider may need to leave some children unsupervised for brief moments (e.g., bathroom breaks) and you will momentarily be left alone with the children. On the other hand, if the caregiver asks you to watch the children while he/she makes a phone call in a different room, you must refuse politely and say that you are not allowed (for liability reasons) to be left alone with the children even if he/she would ordinarily make such calls. Clearly, if a child is in a different room from the caregiver and is in imminent danger, you cannot stand by and watch it happen. You must find ways of ensuring that your presence, including your nonintervention, is not affecting what is going on in the room (e.g., older children hitting you or each other because you are so unresponsive). It may help put caregivers at ease if you say something about the unusual role of an observer who is basically not allowed to act naturally herself.

Try to put the caregiver at ease by reassuring her you are interested in observing a **typical** day, and that you will try to be as unobtrusive as possible. Avoid eye contact with the caregiver and the children so as not to invite conversation or interactions, and try to keep your facial expression neutral. If the caregiver seems eager to talk, tell her there will be time during the interview to cover that particular issue, and make a note to talk about it later -- "I'm afraid I won't finish up in time; let's discuss that later during the interview" might be a helpful deterrent. Also, remember that the closer you are to the caregiver, the more likely it is that you will influence her behavior, so try to find a "vantage point" away from the caregiver from which to observe.

4. Specifics on Behavioral Scales

a. Page 2 information

Available adults: Code the number of adults (over 12 years of age) who are in the same room as the child or, particularly in home settings, within earshot of the child, even if not in the same room. They are not necessarily paying attention to child; they may be involved with their own activities or with other children. Code this at the beginning and at the end of the observation cycle. When the child is out of his/her regular care setting (i.e., the home or center), a more "functional" definition of "available" must be used. Adults standing in a check-out line at the store or bank or library should not be counted. There must be some likelihood that these people would interact with the child; they must be part of some functional "group" of which the child is also part (as would be the case if they were in the child's class at a center or in the child's home). The reason to make this distinction is (a) to make the coding for parks, etc. more comparable to the coding for centers and homes, and (b) to use the coding as the basis for calculating meaningful adult-child ratios. If the park or playground is, in fact, a regular child care setting -- that is, the caregiver takes the child there everyday and they see and interact with the same people there everyday -- then the "functional group" would consist of those adults and children that they see and interact with every day.

Describe each of these adults as a caregiver, friend, volunteer, target child's parent, other parent, etc. For the purposes of the ORCE, a caregiver is defined as anyone who provides regular (at least 10 or more hours per week) care to the target child, or, in the case of group care, in the target child's room. The caregiver may or may not be specifically assigned to the target child. In group care this includes "floaters" who are regular caregivers in the program but divide their time across multiple rooms as long as they typically spend at least 10 hours a week in the target child's room. Some programs will explicitly define caregivers as floaters; others will not. This doesn't matter for our purposes. "Caregiver" also includes "student" teachers, parent volunteers, etc., who may or may not be paid, who spend at least 10 hours per week, at regular times, in the target child's classroom.

"Caregiver" excludes any adult who does not spend at least 10 hours a week, at regular times, in the target child's classroom, such as a center director who periodically passes through the classroom, a parent in a parent co-op who volunteers for less than 10 hours a week, a music teacher (who will undoubtedly spend less than 10 hours a week in the target child's room), etc. These non-caregivers are "other adults" and may be group coded on the line for caregiver 8, if all other slots are filled, or if they are obviously transient -- such as a parent picking up a child or a teacher coming from another room to pick up something. Often, these adults may be present for the day and interact with the Target Child throughout one or more ORCE cycles. In this case, they will not receive a caregiver ID, but may qualify for rating on the Qualitative Scales, and therefore, will require a Caregiver slot of their own so that the behavioral and qualitative data may be identified as belonging to the same person.

A maximum of 3 caregivers on the qualitatives will be coded. Up to 8 "caregivers" will be assigned ID numbers. If "other adults" (for example, you find out after the observation that people you coded as caregivers do not provide care for 10 hours per week for the TC) are coded on the behaviorals, they can be given a place holder (i.e., dummy) ID number such as 0000004, 9999995 etc.

Available other children: Code the number of children who are in the same room as the child. If there are no other children code 00. They may not be paying attention to the child; they may be involved with their own activities, but they are, at least, awake and visible to the child. Code this at the beginning and at the end of the observation cycle.

This estimate of the ages of the available children should be based on a visual guess. Do not stop your observation to ask the caregiver how old each child is. You have seen a lot of children by now. You should recognize (at least) 6-, 15-, 24-, and 36-month-olds. So use your --experienced-- judgement.

Number of children present who are under 12 months of age.

Number of children present who are 12-18 months of age.

Number of children present who are 19-24 months of age.

Number of children present who are 25-36 months of age.

Number of children present who are 37-48 months of age.

Number of children present who are 49-60 months of age.

Number of children present who are greater than 60 months of age,

Asleep children: Record the number of children for whom the adult is responsible who are not "available," but sleeping. Although these children are not available partners for the child, they may affect the caregiver's availability.

b. Specific Scales

ACTIVITY SETTING

At 24/36 months (unlike 15 months), one and only one activity setting code will be checked for each 30-second observation interval. At the beginning of the 30 second period, indicate which one of the following activity settings the child is in at that moment. If the Target Child is in transition between two activity settings, wait until the transition is over before you code the activity setting.

Because things happen more rapidly and over larger spaces at 36 months than at earlier ages, you need to think of activity setting more broadly than before. The potential for interaction at 36 months does not involve necessarily being face-to-face or within arm's reach. Children, and adults, interact across a greater distance.

With adult (and child/ren)

The child is part of an activity in which an adult is involved.

The child and caregiver may be alone, and the interaction one-to-one, or the child may be part of a group of interacting children and adults. The caregiver may or may not be attending to the target child exclusively, but he/she must be involved in the activity in which the child is involved (e.g., building with blocks, playing in sand, reading, watching TV, etc). Just visual supervision from a distance is not sufficient to receive this code. If the caregiver is physically close to the child and watching the child (even if she is not talking to the child), or if she/she is pulling the child in a wagon, or if he/she is at or on the same piece of equipment (e.g., table) and she is watching the child, this would be coded on this scale. If the caregiver is "vegging out," or has her back to the child, even if she is physically close to the child, this would not be coded. If the child is playing with other children and the caregiver is watching from a distance but not interacting with them, this would be activity with child/ren not activity with adult and child/ren.

With child/ren only

The child is playing with another child; they may be playing in parallel, i.e., with the same materials, interactively, imitatively, or cooperatively. Or the child is playing on the same piece of equipment (slide, swings, sandbox, sandtable, table) as another child. Or the child is within 2 1/2 feet of another child (the two children's arms' reach). The children may be eating in adjacent chairs, sitting on adjacent toilets, or painting at adjacent easels, but they are not back-to-back; the target child must be able to see the other without turning around, or the children are in the same activity area and participating in the same activity or talking to each other.

Alone

The child is not involved in an activity with another person (child or adult). This is the default category.

ADULT AVAILABLE

This is really two different issues in homes and in centers. In a home, the issue is whether the caregiver is available to the child; i.e., she may be out of sight but she is still able to hear the child and get to him quickly? For example, she is not available if she is upstairs and the child is downstairs; she is not available if she is outdoors while the child is inside with the door shut. In a center, the issue is how many adults are around -- in the child's "room". Generally the rule about adults in centers is that they are within your view; you don't have to ponder compulsively whether an adult in a center who has disappeared from view is really "available" to the child (lurking just outside the door). You can just do a quick scan of the visible environment.

For each 30-second period indicate which adults (caregivers) were available to the child: able to get to him/her or to respond to him/her within a few seconds (like 5 seconds) in a home, or in the same "room" as the child in a center.

On each ORCE page of a given ORCE cycle, the person labelled as "Caregiver 1" or "Caregiver 2" must be the same person; i.e.,. if Sally Jones is Caregiver 1 in the first ORCE 10-minute segment, then Sally Jones must be Caregiver 1 in the third ORCE 10-minute segment and on the Qualitative Ratings at the end of that cycle. To keep the caregivers straight, write a mnemonic for each (red curly hair, tall blonde, Sally, etc.) Include all adults (over 12 years) who are available here. Code each person on a separate line if they are defined as caregivers. Only caregivers will be assigned IDs. We have allowed room for up to 8 different caregivers for a cycle. If you run into situations where more than 8 different caregivers are available during a single ORCE cycle, use the "Caregiver 8" slot for all of these "extras." An adult talking to the target child on the phone is not available. The caregiver 8 slot is also used for all those people ("others") who come in and out of the situation you are observing and who are not caregivers in the eyes of the Study (caregiver = someone who provides care for the TC for ten hours or more per week). If someone enters the arrangement and you don't know if they are a true "caregiver" then put them in a caregiver slot, on a separate line, and ask at the end of the ORCE. If you know from the beginning that they are not caregivers (i.e. the mail carrier) then put them into slot #8. At the end of the ORCE cycle ask about the unknown people and determine if they are considered caregivers or not. People who are not caregivers will get a place holder ID number such as 000000 or 999999.

Example for a HOME/FDC arrangement - You are about to enter a child care arrangement in which the TC is cared for by her grandmother. You know that she will be in the caregiver #1 slot.
Caregiver #1 = Grandmother

So you start the ORCE with the grandmother in the slot labeled

Caregiver #1 on the Behaviorals. The caregiver's daughter comes in after you have started. She is home from school that day and you know that they all live together (including TC) so you are not sure of this person's status vis a vis the TC. So you put her down on the caregiver #2 slot. Then the mail carrier comes to drop off the mail and stops to say hello, she gets put into the caregiver #8 slot, because you know she does not provide 10 hours or more per week of care. At the end of the ORCE you probe and find out that the daughter does not provide regular care to the TC for ten or more hours per week. Therefore you rate caregiver #1 on the Qualitatives and then put her ID on page 10. For caregiver #2 and #8 you can put a place holder ID, so that you know these people were not caregivers after all - 0000000.

Example for a CENTER arrangement - You are about to enter a center arrangement. You know there will be three caregivers that will be involved in the target child's care while you are at the center doing your observation. You give these 3 caregivers temporary ID numbers.

At the beginning of your first ORCE cycle only 2 of these caregivers are in the room, you put them into slot caregiver #1 and #2 respectively. After you begin coding, the director comes in to visit - you put her into the caregiver #3 slot. Then a parent of another child enters the room to visit his child. You put him into the caregiver #8 slot. Then the third regular caregiver comes in to start her shift, you put her into caregiver #4 slot. Then a caregiver from the next room comes in to help out for a few minutes, she gets put into the caregiver #5 slot. You continue this way adding people as they enter until you don't have any lines left. Then anyone else also gets coded on the caregiver #8 slot as well as all the "others". At the end of the ORCE you put all of these people on your temporary ID sheet. Then ask who all of these people are and figure out who needs actual ID numbers (who is a true "caregiver") and who will get place holder ID numbers.

At the beginning of the second ORCE, everyone has left the room except the 3 main caregivers. You will start this ORCE with them in slots #1, 2, 3, etc.

ADULT INTERACTING

Code which adults interacted with the child during the 30-second interval. Code a caregiver as interacting even if she merely shouts "coming" from the other room, if that "coming" was coded as "Responds to child talk" or "Other talk." If "With adult" is coded for activity setting, "Adult interacting" would also be coded, even if the caregiver doesn't actually "interact" with the child. An adult talking to the target child on the phone is interacting.

LANGUAGE

Child talk

The child says (or sings) something to someone (anything to anyone). The utterance must be in words, or clearly communicative sounds. This can be double coded with Child Behavior scales (verbal aggression, prosocial act, says "no").

Adult language

All other language coded in the ORCE is language by the caregiver (i.e., any adult) to the target child -- either alone or as part of a group of children. This is language actually directed to our child, not just language that our child can hear. It may be said to a small group or to an entire class, but it must be directed to our child. This does not include, therefore, caregiver talking to another child and our child listening. Each of the caregiver's utterance is coded on only one language scale except for responds to child's talk. Behavior recorded on this scale (responds to child's talk) must be coded on one of the other language scales as well. The order in which the scales are listed is the order of priority for coding. Language scales must not be double coded with each other but may be double coded with scales in the adult stimulation category.

Responds to child's talk

The caregiver listens to the child's words or attempts to say words and then responds verbally. She is responding to what the child has said, not what he/she is doing. Example: the child says "Uh, uh," pointing to a dog and the adult says "Doggie. That's a doggie." Child says "Uppy." and the caregiver responds "Shall I pick you up?" The child says "Me go." and the adult says, "You want to go out?" The child says, "I want to go out," and the adult says, "You want to go out?" If the child articulates specific words, the caregiver uses the same words, corrects the child's pronunciation, extends the child's utterance, or answers the child's question. Simply imitating the child's nonverbal vocalization would not be coded here or on any other language scale. This is supposed to be a measure of "high quality" caregiving: the caregiver is responding to the child's talk in a way that might conceivably extend, enhance, or encourage the child's language. The child may grunt and point meaningfully, rather than clearly articulating a word, but in order to be coded on this scale the caregiver has to speak back to the child, not grunt back. She also is not coded if her response to the child's talk is "Shaddup!" This would not encourage the child's speech -- quite the contrary. A response like this that inhibits or stops the child from talking is not coded as responds to child's talk, even though, it is, literally, a response to the child's speech.

Speaks positively to child/ren

The caregiver says something warm, affectionate, or complimentary to the child or the group of children of which the child is a part, e.g.., praises, says "I love you." "You're such a cutie." "Hurray! Yea! You did it!" "Oh, look at how well you're climbing those stairs -- all by yourself." "Good girl." "You silly!!" "Oh, you fat little toad!!" The utterance may be warm in tone of voice or content of utterance. If in doubt, do not code; the utterance should be clearly positive; e.g., not just a "Thank you."

Speaks negatively to child/ren

The caregiver/adult says something negative to the child or the group of children of which the child is a part: finds fault, threatens, speaks with hostility; snaps, insults, scolds, criticizes, yells. Either the caregiver's words or her intonation is negative.

Examples: "Are you dirty again??? I just changed you!" (said harshly) "Stop dragging that blanket all over the house right now!" "Did you hit Mary? Shame on you!" "Stop that right now. Wait till your mother gets here!"

Reads aloud to child/ren

Caregiver/adult reads from book, magazine, paper, or any other written material to the child or to the group that the child is part of. This can be reading single sentences or a complete story, but it is definitely reading, not just pointing at pictures in a book. The child may or may not be listening and learning; the point is only that the caregiver is reading and the child is there. Examples: reading a story at circle time, reading as child falls asleep, reading poster on wall to child. (Reading is reading.)

Asks question to child/ren

The caregiver asks the child a question. Any question, regardless of content, should be coded. Examples: "Are you hungry now?" "Are you excited to see daddy?" "Do you want me to tickle your tummy?" "Who is that? Is that your daddy?" "Where is your nose?" "What do you have?" "Do you want a turn on the swing?" The child may be alone or part of a group but must at least potentially have the opportunity to respond to the question. Include tag questions.

Gives direction to child/ren

The caregiver tells the child to do something or not do something. She gives an order, demand, command, prohibition, or request. "Put them in here." "Go pick up your coat." "Put on your shoes, please." "Here, color with these crayons." "Go find your brother." "Say 'kitty'." "No!" "Keep the crayons on the table." "Take that out of your mouth." "Turn the shirt right side out." "Stop fighting." "Come back here, you are not going out." The demand may be for an action that the child is willing to do or unwilling to do; the child may comply with the request or not comply (the child's compliance is coded under Child's Behavior as "Complies," "Says 'no'/refuses," or "Acts defiant").

This scale does not include indirect demands or suggestions: "Why don't you...?" "Shall we....?" that are better coded as "Asks question." But it does include polite requests: "Would you sit down, please." (Meaning "Sit down.") Or "Can you sit down?" (Meaning "Sit down.") And it does include pragmatic demands: "You need to sit down." (Meaning "Sit down."); "If you don't sit down, then we can't have a story." (Meaning "Sit down."); "I need you to sit down." (Meaning "Sit down."); "It's time for you to sit down." (Meaning "Sit down."); "Let's all sit down now." (Meaning "Sit down."); "We don't stand up on the table." (Meaning "Sit down.") The direction must be for an actual action that the child can do, not a change in the child's emotional state (e.g., "Don't cry." "Don't worry." "C'mon, smile." "Have a nice day.") Gives direction is directing the child's activity, not describing it ("Let's go in now." as they are going in), or comforting the child ("Don't cry."), or giving a general warning ("Be careful." "Don't fall."), or simply drawing the child's attention to something (e.g., saying "Oh, look at the picture of the ..." when they are looking at a book.) "Look at the ..." is considered a suggestion (i.e., other talk), not a direction.

Do not code directions that are in songs or games (For example, If You're Happy and You Know It, Clap Your Hands). This would be coded as Other Talk. Gives direction in response to the child's talk is still gives direction.

Other talk to child/ren

Caregiver directs an utterance to the child individually or as part of a group that has not already been coded as speaks positively or negatively, reads, asks question, or gives direction. The utterance should contain words not just sounds. A single sentence will do. Examples: "Let's go outside." "The bottle's empty -- no more." "Let's put your bib on." Singing also would be other talk. If the caregiver is singing along to a record, this would be coded as other talk to child only if it is directed to the target child; the caregiver would have to be looking at the child, possibly holding the child, not vacuuming or doing the dishes or looking out the window. If the observer cannot hear what is being said clearly, code it as other talk.

STIMULATION

These scales are mutually exclusive; do not double code the same behavior more than once within this category. However, it is quite possible that more than one of these types of behavior would occur within a 30-second period; code each of the different scales that apply.

Teaches academic skill

Caregiver teaches, encourages an academic skill. Academic skills involve the 3 R's: reading, writing, and arithmetic. Specifically, include all activities that involve numbers, shapes, letters, or colors. These activities would include counting (or adding, subtracting, multiplying), naming shapes (this is geometry!), saying (or singing, or reading) the ABCs, pointing out letters or words in a book, spelling, teaching how to read, building with alphabet blocks and labelling them, making playdoh shapes with alphabet cookie cutters and labelling them, labeling or discussing colors, teaching about shapes by showing the child how to put together a puzzle, matching objects, teaching how to make shapes with scissors, crayons (but not just showing how to use scissors or crayons). The teaching must be directed toward the target child. The child may be alone or in a group of children who are receiving a "lesson." The interaction may be playful and enjoyable (e.g., singing the ABCs), or serious and didactic (e.g., Distar).

Teaches social rule

Caregiver teaches a social or moral rule. The content of the social rule may be about sharing, turn taking, hitting, swiping toys, saying "please" and "thank you," giving compliments, expressing feelings of anger or distress verbally rather than physically, showing affection, not hurting people, expressing sympathy or empathy, comforting someone, working together (cooperating), or ownership/possession. The style of the teaching may be saying "Do it." or "Don't do it." or "I like the way you did it." or "I don't like the way you did it." or simply chatting about how it should be done. (But it must be more than a simple "No.") The teaching may or may not include actions (demonstrating, restricting, etc.), but it has to include language or signing. Examples: telling the child to take turns with other children on a slide, suggesting that the child pull another child in a wagon because he would enjoy it or because it is his turn, encouraging children to share, cooperate, take turns, with each other, forbidding child to hit another child, take his toys away, etc. "Be careful you might knock baby over." "I really like the way you shared your ball with Jimmy!" "Say 'thank you.'" "This is Nate's toy and this is David's" (giving a toy to each after David has been trying to take Nate's toy). "That's his playdoh; here is yours. Play with this." "Use your words. Don't hit/cry/push." The caregiver may be teaching the social rule to another child with whom the target child is interacting. The target child may be part of a group of children that is being taught the social rule. But if the caregiver directs the rule to another child in the group by name and the target child is not part of the interaction or paying attention, this would not be coded.

Positive physical contact

The caregiver and child have positive physical contact. The caregiver holds or touches the child -- warmly and comfortingly, affectionately, or playfully. Positive physical contact includes the caregiver's holding the child on her lap, but it is not simply picking the child up to move him/her somewhere and it is not having the child simply sitting on the caregiver's lap and the caregiver not touching the child in any other way. It may occur in the context of caretaking, but it is not routine caretaking alone. It must be active, intentional (not simply touching the child's arm in passing or patting the child's behind repeatedly and absentmindedly while doing something else.) Examples are hugging, kissing, rubbing, stroking, tickling, rocking, swinging, clapping, patting, holding close, hugging, cuddling, rubbing noses, holding in arms while feeding, holding on lap. If the child does the positive physical action to the caregiver and the caregiver ignores it, this would not be coded here.

Mutual exchange

Child and caregiver are engaged in a mutual, two-way interaction in which each person does at least one positive/neutral behavior toward the other (directly or as mediated by materials or a game) in the 30-second observation interval. They laugh or giggle together, just having fun. They play a game or sing a song together in which both are participating. The caregiver gives the child a toy and the child takes it and plays with it while the caregiver talks about it. The two play with the same object (or materials, sand, water, soap, etc) and talk to each other about it. The caregiver entertains while the child watches and may laughs -- or vice versa. The caregiver responds to the child's bid by giving him materials that he then uses, or helping him with materials he is having trouble with and then continues playing with. The child gives a book to the caregiver, which she then reads while he listens. The child and caregiver engage in mutual pretend play. The caregiver tells or reads a story to the child/ren and shows pictures to illustrate it, or she shows pictures or objects to the child/ren and talks about them, and the child is listening attentively and may smile or nod or laugh.

The two do not have to be in direct physical contact or proximity but they do have to be involved with each other. The interaction does not have to be one-to-one; it may involve more than one child or more than one adult. This can occur in the group context if the child is showing active participation contingent on the caregiver's behavior (e.g., if a caregiver is playing with several children and child is participating in the game). The interaction may occur in the context of physical care, if the caregiver and child are playing a game with the food or potty. The interaction may be initiated by the child or the adult. The interaction must be mutual, responsive, and contingent. It can be nonverbal or verbal but if it is verbal it must include other elements -- either positive affect or materials (it can't be verbal alone). It must include more than "Caregiver gives, child takes" or "Caregiver says, child does" -- look for three parts to the interaction: e.g., "Caregiver gives, child takes, caregiver talks." In brief, look for the following cues to a mutual exchange: contingent responding, back-and-forth interaction, positive affect, materials.

PHYSICAL CONTROL

Restrictive actions

The caregiver uses negative physical actions with the child. These include both harsh, punitive negative actions like hitting, shaking, slapping, smacking, yanking, pinching, pushing, kicking, or putting in a physically aversive situation (e.g., out in the cold) in order to punish or control the child. They also include more moderate forms of physical restriction, like putting the child in time out, blocking the child's movements, taking away a toy the child is playing with, holding the child so he/she cannot move, removing the child from an activity he is enjoying, tapping on the child's hand or head to "remind" him that he is not to do something, pulling him away from a place or activity. This is a negative category. It would not be coded in the context of play unless the child clearly didn't want to play. It would not be coded in the context of physical contact or care unless the child was trying to escape or do something else (wriggling, fussing, reaching, etc.). Code in each 30-second segment that activity is restricted. This should be coded according to the caregiver's action rather than the child's reaction to her behavior. It must be clear that the child's activity/wishes/desires or potential activity/wishes/desires are being thwarted, but it is not necessary that the child respond to the restriction negatively (although if he/she does, it is even easier to see that it is a restriction). Some children respond to restriction negatively; others ignore the restriction and turn to other activities. For both, their activities have been physically restricted. What would not be coded would be physically holding the child in a hug that the child is enjoying, or taking away a toy that the child is obviously through playing with. If the caregiver is redirecting a child who is in a predicament (e.g., about to fall down the stairs), this also would not be coded. If the child is restricted in a car seat, this would not be coded.

CHILD'S ACTIVITY

All the child's activities that last for at least 5 continuous seconds are coded on one of these scales. There can be more than one for each interval if more than one activity occurred for more than 5 seconds. Only if no activity in the interval lasted 5 or more seconds would this category be left blank. With one exception, the activity scales are mutually exclusive; a single activity cannot be coded on more than one of these scales. The exception is watching TV. This scale may be double coded with another scale in this category. For activities other than watching TV, if an activity seems to fit more than one scale (e.g., the child is engaged in activity with objects interspersed with brief intervals of watching), code it at the highest level observed (i.e., in the order of priority in which the scales appear on the form). If the child is eating and also talking to the caregiver about going to the zoo, or if the child is dressing and singing with the caregiver at the same time, these would be considered two activities (physical care and without objects), and both would be coded.

Activity with objects

The child is involved in an activity with an object or objects. These objects would include books, toys, paints, kitchen utensils, pets, food that someone other than the child is eating, playground equipment (swings, slide, trampoline, jungle gym), tricycles, water in a swimming pool, even dirt and sand -- if they are being used as objects (i.e., the child is playing with them, building, experimenting, exploring). The child must be clearly involved with the object and interested in the activity, not just passing time. He is watching, exploring, manipulating, or playing with the object. Swings and mirrors are coded as objects. If the target child is in a car, ignore the fact that the child is in the car just look at what the child's activity is. If the caregiver is reading a book to the child/ren and showing pictures in it, this would be coded as an activity with object.

Activity without objects

The child is involved in an activity that does not involve objects, e.g., singing songs, gross motor activity (running, jumping, walking on a line), rough and tumble play, listening to a story (but not holding or looking at the book), playing a game, holding an infant, tickling the caregiver (or vice versa). If the caregiver is reading a book to the child/ren and not showing pictures in it, this would be coded as activity without objects. "Pretending" about non-existent objects is without objects. Talking about objects that are not actually present or touchable is without objects. Being pushed in a stroller is with objects; sitting in a stroller is without objects. Carrying or holding the child on the lap, holding hands are included.

Physical care

Child is given physical caretaking by caregiver or engages in physical care activities by himself. Physical care activities are those necessary to take care of the child's physical needs. Examples: dressing, diapering, going to the bathroom, going potty, washing, taking a bath, feeding, eating, drinking, rocking to sleep, putting on a sweater. Physical care does not include giving the child a pacifier or a wipe of a nose that lasts less than 5 seconds. Code this activity from the beginning, e.g., when the caregiver says "Let's go sit on the potty." until the end, e.g., the child is off the potty and dressed again. When the child is playing with his shoelaces, this is not physical care; putting on his shoes is, and so is tying his shoelaces if the child is going to trip over them.

Watching/unoccupied/transition

The child is awake, but not engaged in any observable activity. He may be waiting for the next activity to start (before eating, before going out), or he/she may be watching other people (adults or children) but not interacting with them. The other people are ignoring the child. They may be across the room or close up, but they are clearly not interacting with the child. It may be the observer who is being watched by the child. The child may be watching an event or object at a distance, but he cannot reach the object and no one is talking to him about it. The child is not doing anything else at the same time (using or exploring a toy, interacting with anyone, being held). He/she may be holding a toy in his/her hands or mouth, but is not exploring it. He/she may be wandering around the room or walking from one place to another but not running or jumping in fun. He/she may be alone in the crib and falling asleep. He/She may be in "time out." He/She may be sucking his thumb or a lollipop but is not exploring them. He/she may be near other children or adults or alone.

Watching TV

The TV is on and the child is looking at it. Do not code if the TV is simply on throughout the visit. Code only in those intervals that the child watched the TV for at least 5 continuous seconds.

CHILD'S INTERACTION WITH OTHER CHILDREN

"Other children" are children under 13 years. For this category, first decide "Is there peer interaction?" (parallel play is not peer interaction). Then decide, "Is the interaction (a) mutual pretend, (b) negative, or (c) anything else."

Mutual pretend play

The target child engages with another child or children in fantasy play, make believe, pretense. They use materials symbolically -- pretending that a sprinkler is a waterfall, "drinking" from empty cups, "meowing" like kittens, constructing balls or snakes out of playdoh and playing with them as if they were balls or snakes instead of playdoh (they throw the "ball," wiggle or "hiss" the "snake"). They play house, doctor, school. There must be at least two children involved; they must be interacting, not just playing pretend in parallel; they must both be pretending, not just one of them; and it must be clear they are pretending (using materials symbolically or playing roles not just using pretend-type materials such as dress-up clothes). For block and playdoh play, the children must say they are making a "tower," "snake" etc., not just pile blocks into a tower shape or roll the playdoh into a snake shape.

Negative interaction

The target child gives or receives a negative -- unfriendly -- overture from another child or children: verbal or physical aggression or negative act. The target child may be the victim or the initiator of the negative interaction.

Positive/neutral interaction

Any positive or neutral social interaction with a peer or peers that has not been coded as mutual pretend. The child gives or receives any social overtures from other children -- e.g., playing with the same object, offering an object (even if it is not accepted), mutual smiling, sharing a toy, taking turns, playing cooperatively, This includes both high level, cooperative engagements between children and relatively simple attempts at interaction. Accidental bumps etc. should not be coded.

CHILD'S BEHAVIOR

Do not double code scales within this category.

Prosocial act

The child helps or expresses sympathy toward another person (adult or child). He/she gives the other person a toy (as a "gift" not as part of play or in response to a request). He/she comforts, hugs, cuddles or kisses another person (including hugging back after the other initiates a hug, but not including a hug initiated by the other.) It must be clear that the target child has initiated the prosocial act. If in doubt do not code. He/she plays with another child enthusiastically and affectionately or cooperatively, at a high level of positive interaction. The act must be clearly positive, not just social. If the caregiver is directing the children's play, it is unlikely to reach this "prosocial" level.

Negative act (nonaggressive)

The child makes an unfriendly but not aggressive act toward another person (adult or child) -- e.g., taking away toy that child wanted or was playing with, interfering with other child's activity, attempting to take something away from other child forcibly (pulling hard, removing the other child's hand from the toy), saying "no", "mine" to other child, yelling or whining "mine" to other child or adult, sticking out tongue at caregiver. Accidental bumps should not be coded. The act should be deliberate, but its intention should not be to hurt the other person. Code the child's behavior as a negative act even if the caregiver tells (prompts) the child to do it (e.g., "Just tell him you don't want him to take your toy." Why don't you take it back?"

Verbal aggression

The child says something aggressive -- name calling, teasing, jeering, derogating, threatening -- to another person (adult or child). Do not include fantasy aggression (e.g., pretending to shoot another child with a mock gun -- "Bang, bang!") or playful aggression (verbal aggression that is clearly playful -- all participants are usually smiling or laughing or clearly enjoying themselves.

Physical aggression

The child does something aggressive -- e.g., hitting, kicking, fighting, banging, biting, spitting -- to another person (adult or child). There is a physical attack or threat. Do not include fantasy or playful aggression (e.g., pretending to shoot another child with a mock gun) or playful aggression (e.g., two children rolling on ground together laughing and smiling while grabbing each other; two children exchanging mock punches and laughing). Code the child's behavior as aggression even if the caregiver tells (prompts) the child to do it

(e.g.. "Just fight back!" "Push him back.")

Complies with adult

The child complies with a direction that has been coded as Gives direction, or Speaks negatively. Examples: the caregiver says "Show me the box." -- and the child does. The caregiver says "Go get the box." -- and the child does. The child must at least start to comply within the 30-second interval in which the request/order was given, but the behavior may be completed in a subsequent interval. It would not be coded as complies again in the subsequent interval if it was coded in the first. Do not code complies to a nonverbal suggestion by the caregiver. If the caregiver is forcing the child to comply (by pushing him, for example), this would be coded as complies (and also as Restricts for the caregiver).

Says "no"/refuses to adult

The child exhibits autonomy or assertiveness by saying "no" or "mine" or some other emphatic but non-angry expression, verbal or nonverbal, when the caregiver gives a direction or suggestion, speaks negatively, introduces an activity, etc. For example, shaking head "no," holding object tightly to self, turning back to caregiver, or not doing what the caregiver requested, but without acting angry or defiant. Must be a deliberate refusal, within the 30 second period, not just ignoring the caregiver's direction as if the child didn't hear or understand. The child's refusal may be polite or whiny, but it is not angry.

If the Target Child's negative behavior towards a caregiver is in response to a caregiver's request or command then code it under the appropriate category - either Says No or Acts Defiant. If the child's negative behavior is not connected to a command or request given by the caregiver then code it under Negative Act or Physical Aggression.

Acts defiant to adult

When the caregiver tries to control the child, through a direction, prohibition, suggestion, question, or physical action, the child acts defiant: angry, yelling, aggressive, or intensifying the prohibited behavior.

5. 36-Month Qualitative Ratings

a. Caregiver ratings

Sensitivity/Responsivity

The key defining characteristic of sensitivity is that it is child-centered. The sensitive caregiver is tuned in to the child and manifests awareness of the child's needs, moods, interests, and capabilities, and allows this awareness to guide his/her behavior with the child. In preschoolers this includes sensitivity to the child's own agenda, needs for autonomy, independence, and mastery, and individual self-regulatory abilities (and deficiencies). The sensitive caregiver of 3 year-olds structures the child's physical and social environment so that the child has legitimate, interesting options for play, so the child's preferences can be honored within reason, and so that the child can remain effectively engaged in playful or goal-directed activity. The sensitive caregiver offers the right mix of support and independence so that the child can experience mastery, success, pride, and develop effective self-regulation skills. Examples of sensitivity may be seen during transitions such as when a caregiver prepares the child in advance for changing activities.

If the child appears disengaged, the sensitive caregiver takes time to reengage the child in a manner that demonstrates awareness of and sensitivity to the child's mood and preferences for play style and content. When the child is bored or frustrated, the caregiver offers toys, activities, or other engaging opportunities; or helps the child decide what to get involved with or help the child make the transition to the new activity. When the child is interested and involved with toys, the sensitive caregiver allows him/her time to independently explore them.

Children also have the need at this age to spend sometime playing alone, just sitting quietly or watching others. Sensitive caregivers do not demand participation in activities at all times; neither do they ignore an aimless child.

As much as possible the 3 year-old is given choices for play. This includes providing choices of toys and how to play with them, or choices among caregiver structured activities, among roles in a game and so forth. How and what they play is geared to whether or not the child seems to be enjoying the activity. The caregiver does not persist with an activity which the child is obviously not enjoying, rather the caregiver tries to engage the child's interest by appealing to the child. For example, if a child doesn't want to sing with the group during circle time, the caregiver might ask the child to choose a song, allow the child some time before joining the groups, or seeks ways of involving the three-year-olds both more active and reactive in their likes and dislikes. Unlike with infants, it is not always best for them to "have their own way." The sensitive caregiver, however, permits the child as much choice, control, and autonomy as possible even while enforcing necessary rules, regulations, and constraints.

A sensitive caregiver provides stimulation that is situationally appropriate. He/she acknowledges the child's interest, efforts, affect, and accomplishments. Sensitive caregivers need not spend all the time engaged with the child, but the difference between them and the detached caregiver is that the sensitive caregiver seems to be actively taking an interest in the child's activities, as evidenced by comments, embellishments, or redirection when the child loses interest, achieves success or does something new and interesting. It is at these times that the difference between the sensitive caregiver and the detached, understimulating caregiver is most easily seen; the detached caregiver does not respond, responds in a listless manner, or responds with developmentally inappropriate comments and behavior. The insensitive caregiver could also be overstimulating/intrusive and might continue in his/her attempts to engage the child even when the child is providing clues that he/she is seeking to end the interaction.

A sensitive interaction is well timed and paced to the child's responses, a function of its child-centered nature. Such an interaction appears to be "in sync." If the child initiates interaction with the caregiver or makes demands, desires, or requests known, the sensitive caregiver responds appropriately, based on the child's behavior and speech. The caregiver paces activities to keep the child engaged and interested, but also allows him/her to disengage if interest is lost and generally to shape the nature of the involvement.

Many preschoolers are increasingly interested in play with peers. A sensitive caregiver allows children the opportunity to play alone. A sensitive caregiver allows children the freedom to play together and resolve their own squabbles. However, she or he also intervenes, when necessary, if scrabbles escalate or repeated aggressive encounters occur. Sensitive interventions may take the form of introducing new activities, re-organizing play materials, or working with the children on active social problem solving techniques.

During the preschool years, sensitivity can also be inferred on the basis of how the caregiver manages disciplinary encounters. The sensitive caregiver is neither over controlling or detached, but rather is attentive to child behaviors that need sanctioning and responds in a way whereby the sanction fits the misdeed. Thus, behaviors that pose dangers to the child and others are responded to quickly and clearly and perhaps firmly (though not severely) in order to let the child know clearly that such actions are not permitted. Behaviors, in contrast, that represent rule violations (e.g., going to a part of the house that is off limits for cleanliness reasons) or discourtesies (e.g., taking another's toys) should be responded to less severely and perhaps with somewhat less immediacy (due to the absence of physical danger). Sensitive discipline frequently involves indication by the caregiver that he/she is aware of what motivates the child (e.g., "I know you wanted that toy;" "It's difficult to stay away from such pretty things, isn't it?") and the offering of an explanation or rationale for why the discipline is taking place (e.g., "That's dangerous, so I can't let you play with it;" "Sarah had the toy first, so she gets to keep it for now"), and/or a substituting toy or activity (e.g., "You may not pull out the colors now, but I will read you a book"). To be noted, however, is that excessive explanations and rationales can reflect insensitive-intrusive caregiving rather than sensitive caregiving. Long-winded speeches and lectures often reflect the caregiver's lack of awareness of the child's developmental level. Prohibitions that are at the whim of the caregiver rather than in keeping with appropriate guidelines for preschoolers are not "child centered." Similarly, prohibitions that the child is incapable of understanding are manifestations of insensitive discipline. Insensitivity is also manifested by an inadequate provision of resources, or setting up situations in which conflicts are inevitable. An example of this insensitivity is a caregiver giving one child a highly desirable toy and expecting other children to watch and wait their turn for extended periods without providing appropriate alternative activities or materials. In sum, sensitive discipline is discipline that varies in accordance with the nature of the misdeed and suggests that the caregiver does not hold inappropriate expectations of the child in question.

Sensitivity can also be manifested in the caregiver's response to the child's distress, anger or frustration. Sensitivity may involve speaking sympathetically to the child, approaching the child, redirecting the child's activities, hugging, patting, picking up, or holding in lap and rocking. For preschoolers, physical contact is not always the most effective or even the most appropriate response to distress. Much depends on the intensity and cause of the distress. Calm reassurance, explanations, or negotiations are appropriate responses when the distress had a clear explainable cause. When the cause of distress is unknown, the sensitive caregiver will try to determine the cause by asking the child. In addition to reassuring the child, the sensitive caregiver will attempt to alleviate the cause, where possible (e.g., speak to another child who was the cause of the distress; help with a frustrating physical world problem).

Markers of sensitivity include (a) acknowledging the child's affect; (b) caregiver conversation that is responsive to the content of the child's talk and or activity; (c) facilitating, but not over controlling the child's play with objects or peers motor activity; (d) appropriate timing of activities to reflect children's interest (e) changing the pace when the child appears understimulated, overexcited, or tired; (f) picking up on the child's interest in peers, toys, or games; (g) shared positive affect; (h) providing an appropriate level of stimulation and appropriate range and variety of activities; (i) timely discipline that matches the nature of the violation under consideration and the child's ability to understand and benefit from whatever reprimand is offered; and (j) general flexibility in handling compliance and autonomy issues, including not over-reacting to noncompliance and supporting autonomy while permitting dependence.

Thus, the sensitive caregiver demonstrates the ability to adapt her/his behavior to the child's mood and level of development. The caregiver neither over- nor underestimates. The caregiver knows when it is time to increase or reduce the amount of stimulation the child is experiencing. For example, the caregiver discontinues an activity that is beyond the child's capacity for response or introduces a new activity when the child appears bored.

Ratings on this scale should be based on both quality and quantity of caregiver behavior.

1 = Not at all characteristic. There is little evidence of caregiver sensitivity. The caregiver rarely, if ever, responds appropriately to the child's cues, or manifests an awareness of the child's needs. Interactions are characteristically ill timed or inappropriate.

2 = Minimally characteristic. This rating should be given to caregivers who display infrequent or weak sensitivity/responsivity. While the caregiver is sometimes sensitive the balance is clearly in the direction of insensitivity to the child's needs.

3 = Moderately characteristic. This rating should be given to caregivers who are predominantly sensitive/responsive. The caregiver demonstrates sensitivity in many interactions but not in others, or may show some insensitivity while being predominantly sensitive (e.g., available and responsive to child's needs but some responses are more adult-driven than child driven).

4 = Highly characteristic. This rating should be given to caregivers who are exceptionally sensitive and responsive to nondistress. Insensitivity is rare. Interactions are

characteristically well timed and appropriate, meeting the child's developmental needs. If the child is busy, engaged, and happy, then a caregiver need not directly interact with the child. However, if the caregiver is "zoned out", preoccupied or detached then her or she is not sensitive even if the child is engaged.

Intrusiveness/Over Control

Intrusive and overcontrolling interaction is definitely adult centered rather than child centered. Prototypically, intrusive/overcontrolling caregivers impose their agenda on the child. Some intrusive/overcontrolling caregivers overstructure 3 year-olds' play; they insist on their own agenda or play theme; they interrupt to redirect play; or they insist on particular uses for toys or props (e.g., "it's an apron not a hat"; an oven cannot be a space shuttle), when such control is not necessary for the child's safety or respect for others or their belongings. These caregivers appear unable to relinquish control of the interaction in order to facilitate the child's exploration or regulation of the activity. Extreme intrusiveness can be seen as overcontrol to a point where the child's autonomy is at stake. It should be kept in mind that a caregiver can be involved in play with the child without being highly intrusive, if the caregiver follows the child's interest, pace, and signals.

Intrusive, over control is sometimes observed during disciplinary encounters. The intrusive-overcontrolling caregiver appears unresponsive to the whys and wherefore of a child's behavior, and instead imposes a system of rigid values and responses. Moreover, this kind of caregiving seems more driven by the caregiver's own moods and inflexible attitudes than by the developmental needs of the child. Thus, little distinction may be made in whether the caregiver is disciplining the child for engaging in truly dangerous behavior versus engaging in simply inappropriate or impolite behavior. In such instances, the caregiver does not modify the severity of her discipline in accordance with the seriousness of the child's behavior, or the child own sensitivity to discipline styles, and is likely to show little interest or concern for the child's feelings or goals. Punishments by highly controlling and intrusive caregivers are likely to not vary as a function of the severity of the misdemeanor and may reflect inappropriate expectations of what the child can be expected to do (e.g., extended time-outs, forcing a child to stand in a corner). It should be noted, too, that another way a caregiver can be intrusive and overcontrolling with regard to discipline is by over doing what would otherwise be judged appropriate caregiver behavior; for example, by going on endlessly explaining to a child why he/she should not do something or excessively drawing a child's attention to the consequences of his/her actions.

Specific behaviors characterizing intrusive/overcontrolling interactions include (a) offering a continuous barrage of talk; (b) not allowing the child to select activities or toys; (c) changing activities while the child still appears interested, without preparing child for a transition; (d) insisting that the child do something in which he/she is not interested; (e) not allowing the child to make choices, and (f) by excessively or abruptly disciplining the child.

Caregiver actions which are clearly in the child's best interests, such as removing a child from danger, administering medicine, intervening in escalating or physical conflict, or putting an obviously tired child to bed, are not included in considerations of intrusiveness.

Ratings of intrusiveness are evaluated from the perspective of the child.

1 = Not at all characteristic. This rating should be given to caregivers who display no signs of intrusive or overcontrolling behavior.

2 = Minimally characteristic. This rating should be given to caregivers who display minimal intrusiveness. There is some evidence of intrusiveness, but it is not typical. The caregiver initiates some activities that are not welcome or are ill timed. The caregiver may terminate activities in which the child is still engaged without adequate warning or transition time.

3 = Moderately characteristic. This rating should be given to caregivers who are often intrusive/overcontrolling. Caregiver intrusiveness occurs in some interactions at a fairly high level, but is often totally absent; or moderately intrusive/controlling behavior is evident more often; or for caregivers who rarely interact, a substantial proportion of their interactions are intrusive.

4 = Highly characteristic. This caregiver's interactions with the child are consistently and typically intrusive. During their

interaction, the caregiver controls the interaction, allowing the child little self-direction in his/her activities. During the time that they are interacting, the caregiver allows the child little autonomy, and essentially negates the child's experience.

Detachment/Disengagement

The detached/disengaged caregiver appears emotionally uninvolved or disengaged, and unaware of the child's needs for appropriate interaction to facilitate involvement with objects or people. There is little joining in the child's play, participating in conversation, or even awareness of what the child is doing. Detached caregivers don't respond to the child's attempts to interact with them, signals of frustration or difficulty in goal-directed behavior, and initiations or escalations of peer conflict. Moreover, when caregivers do get around to interacting with the child, their behaviors are perfunctory and signal noninvolvement. Allowing the child to play by him/herself is not necessarily a sign of detachment; this is appropriate when the child is playing happily or contentedly. This is especially true of preschoolers who must be given time, space, and independence to explore the object and social worlds. If the caregiver is involved and busy with children while the focal is constructively engaged and happy then we would rate the caregiver as low in detachment. However, if the child is involved and busy and the caregiver is passive, and/or lacks the emotional involvement with other children or the focal child, the caregiver is rated as detached. A detached caregiver appears uninterested in the child, the child's activities, and the child's successes, failures, and struggles.

During the preschool years, detached caregiving is often evident in the disciplinary encounters that do NOT take place or in the insufficiency of those that do occur. Detached/undercontrolling caregivers often fail to act when potentially dangerous situations arise or when peer conflicts get out of hand or when the child is doing something that he/she has been told he/she should not be doing. At the extreme, detached caregivers simply fail to monitor the appropriateness of child behavior so that they can step in when some kind of discipline or adult control is called for. It may also be the case that detached caregivers simply fail to follow through with their stated intents (e.g., tell a child he will get a time out if he does a particular action again, but then failing to give the time out when the action re-occurs) or do so in a too-limited or inconsistent manner (e.g., instead of giving the time out, repeat the warning; start to give the time out, but then get distracted).

A caregiver receiving a high rating for detachment/disengagement is considered to be insensitive.

Detachment can be marked by (a) the child being out of sight of the caregiver for extended periods without the caregiver checking in to see what the child is up to; (b) rarely being involved with the child in play, learning or conversation; (c) failing to respond to the child's approaches, vocalizations, smiles, or other social bids; (d) evident lack of awareness of the child's engagement in inappropriate behavior; (e) failing to respond to behavior and situations that call for adult regulation of child experience or responding half-heartedly and inconsistently, (f) permitting long stretches of unoccupied time or wandering without directing the child to an activity; (g) ignoring the child's difficulties with the physical environment, especially where such difficulties are emotionally stressful for the child, e.g., escalating problems with peers, problems getting blocks to stack, etc. The sensitive caregiver permits the child ample opportunity to try to solve the problem by herself, stepping in when necessary to prevent too much frustration or disappointment. The intrusive caregiver steps in too soon, never allowing the child the autonomy to try to solve the problem himself. The detached caregiver doesn't step in at all, or only when the child is so distressed that it cannot be ignored; and (h) says, or conveys nonverbally, "don't bother me; stay out of my way; leave me alone." Some detached caregivers place an overemphasis on the physical setting and other adults (e.g., visiting with other caregivers, filling out forms, straightening the room) instead of attending to the child.

This scale contains both qualitative and quantitative components. A caregiver who interacts consistently with the child but does so in a perfunctory or indifferent manner with little or no emotional involvement would be rated high on detachment.

Exactly how high the rating should be will depend on the extent of child behavior that merits efforts by the caregiver to control and regulate it but which go uncontrolled and unregulated by caregiver.

1 = Not at all characteristic. This rating should be given to caregivers who display no signs of detachment or underinvolvement. When interacting with the child, the caregiver

is clearly emotionally involved. And when not interacting with the child these caregivers are aware of what the child is doing.

2 = Minimally characteristic. This rating should be given to caregivers who display minimal detachment while the caregiver is a bit disengaged, he/she is clearly more involved than not.

3 = Moderately characteristic. This rating should be given to caregivers who are mostly detached. The caregiver is unaware of what the child is doing and where s/he is at fairly often.

4 = Highly characteristic. The child spends virtually all of his/her time without caregiver attention, or at best only visual attention. In the minimal instances of involvement, the caregiver's behaviors are simple, mechanical, stereotyped, repetitive, and perfunctory. The caregiver is clearly not emotionally involved with the child, and appears to be "just going through the motions."

Stimulation of Cognitive Development

This scale measures the degree to which the caregiver tries to foster the child's cognitive and mental development. A stimulating caregiver may take advantage of even routine activities (snack, playground, walks, cleanup) to stimulate development, and will consistently engage in a variety of explicit activities with the intent to facilitate learning. The caregiver will make deliberate attempts to encourage the child's development, achievement, and learning.

Behaviors characterizing stimulation include (a) talking about and demonstrating aspects of the physical world; (b) focusing the child's attention on the unique attributes and perceptual qualities of objects (i.e., their colors, how they move, what they can be used for); (c) suggesting more sophisticated play activities (e.g., "why don't you try..."); (d) verbally responding to and expanding on the child's verbalizations or vocalizations; and (e) encouraging the child to actively participate in activities. However, this scale does not assess the extent to which caregivers provide learning materials. High scores are given to caregivers who (a) describe, label, or ask questions about toys or objects, or demonstrate how they work; (b) stimulate the child's language development and expand on their verbalizations; (c) elaborate on text from storybooks; (d) encourage and reinforce the child's attempts at mastery, or challenge the child to try something new; (e) present activities in an organized sequence of steps; (f) teach the child or give him/her an opportunity to experiment with materials that illustrate or teach concepts; (g) ask questions that require problem solving; (h) label and interpret the child's experiences, (e.g. "You think that's funny"); and so on.

Physical activities such as rough and tumble play, swinging, and climbing are not considered as stimulating development in terms of this rating, unless the caregiver uses language (or other devices) to emphasize cognitive aspects of the experience. Nor do those activities that are only social (hugging or smiling) or caretaking (soothing) qualify as stimulation of development in terms of this rating scale.

The focus of this scale is on the caregiver's effortful teaching that may ultimately enhance perceptual, cognitive, and linguistic development. Stimulation of development can occur in group learning situations such as circle time and snack if the focal child is attending to the caregiver. If the topic or method of stimulating is poorly matched to focal child's developmental level or interest then, the caregiver's behavior is not seen as stimulating development. For example, efforts to teach a three-year-old to print his name (when he can not hold a pencil and does not want to try to hold the pencil) are not cognitively stimulating. Another example of low or limited stimulation is reading a book to a child who is uninterested in the book.

1 = Not at all characteristic. The caregiver makes almost no attempts to teach the child anything or provide any stimulation.

2 = Minimally characteristic. This rating should be given to caregivers who provide infrequent or weak stimulation. The caregiver's conscious and purposeful attempts to engage in development-fostering experiences are limited.

3 = Moderately characteristic. This rating should be given to caregivers who provide adequate stimulation but could reasonably be expected to provide more and higher-quality stimulation. The caregiver makes an effort to provide stimulation, but does not consistently take advantage of opportunities to do so. Stimulation is not the main agenda. The caregiver finds new ways to engage the child with toys, for example, but these ways are limited in number and/or quality. Actions are likely to be simply repeated rather than thoughtfully varied. Caregivers who

provide a rich linguistic environment but do not stimulate problem solving, pretend play, or other more cognitively stimulating experiences would receive this rating.

4 = Very characteristic. This rating should be given to the caregiver who is consistently stimulating and takes advantage of many activities as opportunities for stimulation. The caregiver provides frequent and high quality stimulation through "lessons," explanations, and activities. Teaching or fostering development characterizes the caregiver's frequent interactions with the child. The caregiver thoughtfully varies and elaborates on these activities, providing numerous opportunities which are cognitively exceptionally advantageous to the child. He/she provides rich stimulation in terms of language, and embellishment of the potential of the physical and neutral world.

Fostering Exploration (Mark Bailey was instrumental in the development of this scale)

This scale measures the degree to which a caregiver fosters the child's exploration of his/her environment. A caregiver who fosters exploration may do so in several ways, for instance: (a) by arranging physical environment to encourage independent exploration; (b) by allowing constructive exploratory activities to continue without intervention; (c) by actively suggesting and encouraging exploratory activities.

An environment that fosters exploration is child-centered and encourages children to make choices for themselves. Such an environment may contain a variety of manipulative materials accessible to the child such as: learning centers filled with interesting objects such as a display of unusual sea shells; materials that inspire exploration of the physical senses such as bubble/water table; enticing learning materials that provide self-correcting feedback such as color/height seriation rods; art supplies with a variety of application such as an assortment of collage materials; tools that encourage exploration such as a magnifying glass.

Caregivers may also foster exploration by nonintervention in the child's systematic manipulation of the environment. These activities can include traditional avenues of active exploration such as the child's building a structure with blocks or trying different brush strokes at an easel to unusual, unexpected or even messy activities that are safe and stimulating. Examples include: allowing children to use art materials for things other than what they were intended such as face painting with finger paint; tolerating we children when they are engrossed in constructive watertable play; permitting the combination of different learning materials such as puzzles with dinosaurs and trucks in order to enact fantasy play. Another manner in which caregivers may foster exploration is through he strategically timed facilitation of children's activities. There are a variety of ways to actively foster exploration: if a caregiver notices that a child is losing interest in an activity, suggesting new variations may spark creative interest; a caregiver may sit down at a learning center and use the materials thereby serving as an implicit model for exploration. A caregiver who fosters exploration may provide just the right tool to a group of children wondering what to try next to dig their "buried treasure" out of the ground.

The focus of this scale is on the amount and quality of environmental preparation, accessible materials and caregiver facilitation that may ultimately foster exploration. Simply allowing children to explore a well prepared environment is considered fostering of exploration; however, highest ratings will be given to the caregiver who is attentive to the child's needs and provides facilitative comments and materials when appropriate, unless facilitative efforts on the caregiver's part do not appear to be warranted for the child to be actively engaged in exploration. Low scores on the scales will be given when caregivers (a) abruptly force a child without preparation to stop constructive exploration for little or no apparent reason, (b) narrowly constrain the child's access to materials by offering an environment with few opportunities for exploration, (c) limit what the child can do with materials, or (d) do not assist, support or encourage a child's exploration when interest or ability is lacking.

Caregivers do not receive high scores on this scale if the children's exploration consists of dangerous or destructive activities without appropriate intervention and redirection.

1 = Not at all characteristic. The caregiver allows or provides for very little exploration. He/She provides a teacher-centered environment with limited access to materials, is restrictive in the use of the materials, or narrowly restricts exploration to fit his/her agenda.

2 = Minimally characteristic. The caregiver allows or provides for a minimal amount of exploration. The caregivers' main agenda is not child-centered exploration, however they provide some materials which foster limited exploration and/or they encourage exploration on some occasions.

3 = Moderately characteristic. The caregivers foster exploration. The caregiver provides a child-centered environment and makes an effort to foster exploration. The caregivers have constructed an environment containing a variety of materials, but exploration is limited in duration, quality and available materials, in comparison to the opportunities provided by caregivers receiving a "4" rating. Facilitation of exploration by the caregiver, if needed, is not consistently provided.

4 = Very characteristic. The caregiver fosters rich and extensive exploration. The caregiver provides a child-centered environment full of many interesting materials and consistently allows or facilitates many or extended opportunities for exploration. If the child's exploration is purposeful and engaged, the caregiver need not directly interact with the child for extended periods of time. The caregiver is flexible and able to accommodate the child's creative ideas. The caregiver is attentive to the child's exploration.

Positive Regard for the Child

This scale rates the caregiver's positive feelings toward the child. Positive regard can be demonstrated during group interaction such as circle time when caregiver displays warmth, acceptance and respect for children in circle. In addition, positive regard is shown by (a) speaking in a warm tone of voice to the focal child; (b) hugging or other expressions of physical affection to the focal child; (c) smiling or laughing with the child; (d) enthusiasm about the child; (e) praising the child; and (f) clear enjoyment of the child. Positive regard is evident when the caregiver listens, watches attentively, looks into the child's face when talking to him/her.

Ratings on this scale are based on both quality and quantity of positive regard.

1 = Not at all characteristic. This rating should be given to caregivers who display no positive regard.

2 = Minimally characteristic. This rating should be given to caregivers who display infrequent or weak signals of positive regard.

3 = Moderately characteristic. This rating should be given to caregivers who are typically positive about and with the child.

4 = Very characteristic. This rating should be given to caregivers who are strongly positive.

Negative Regard for the Child

This scale rates the caregiver's negative regard for the child. Both frequency and intensity of negative affect toward the child are considered. Some markers of negative regard include (a) disapproval; (b) tense body; (c) negative voice when correcting; (d) abruptness;

(e) tense facial muscles and strained expression; (f) harshness; (g) sarcasm; (h) threatening the child; or (i) harsh punishment; and (j) roughness. Children's bids for autonomy and noncompliance bids may elicit anger or rough handling. Disciplinary measures may or may not convey negative regard to the child. For example, if the child bites or pulls another child's hair, and the caregiver yells with an angry voice, this exchange conveys some negative regard. If, however, the caregiver speaks firmly to the child regarding the child's behavior this is not in and of itself negative regard.

Ratings on this scale are composed of both qualitative and quantitative evaluations. The amount and intensity of negative regard exhibited is evaluated in relation to the duration of the observation period.

1 = Not at all characteristic. This rating should be given to caregivers who do not display negative regard for the child either in words or in expressions. No evidence of anger, distrust, frustration, impatience, disgust, general dislike, or other indicators of negative regard is observed in the caregiver's face or voice. The caregiver may be expressionless or flat, or positive.

2 = Minimally characteristic. This rating should be given to caregivers who display minimal negative regard. There is some evidence of low-intensity negative regard.

3 = Moderately characteristic. This rating should be given to caregivers who regularly display negative regard. Multiple instances of low-intensity negative regard or some evidence of

more-intense negative regard is observed.

4 = Highly characteristic. This rating should be given to caregivers who are extremely negative. Feelings of negative regard are expressed strongly and repeatedly, or persistent moderate levels of negative regard are expressed. The overriding affect influencing the caregiver-child interactions is negative.

Flatness of Affect

This scale measures how animated the caregiver is with the focal child and others in the room. Flat affect may reflect boredom, depression, fatigue, or distraction. Flatness is exhibited by blank, impassive facial expression, and flat tone in vocal expression. It is marked by a lack of animation. If the caregiver is watching the child with interest (eyes "bright"), it is a sign that the caregiver's affect is not flat. This scale assesses the caregiver's overall demeanor, not just animation with the target child.

1 = Not at all characteristic. This rating should be given to caregivers who exhibit almost no flatness. The caregiver's demeanor and behavior are consistently animated.

2 = Minimally characteristic. This rating should be given to caregivers who exhibit some flatness. The caregiver is usually animated, but there are occasions when facial expression and/or voice is blank and impassive.

3 = Moderately characteristic. This rating should be given to caregivers who are mostly flat. Some periods of animation alternate with more clear periods of flatness than observed for a

score of 2. Flat affect predominates.

4 = Highly characteristic. This rating should be given to caregivers who are consistently flat. There is consistent absence of animation.

b. Child ratings

Positive Mood

Indicators of child positive mood include smiles, laughter, and positive tone of voice, as well as enthusiasm expressed. Lack of positive affect may be manifested by a neutrality or negative mood.

Ratings on this scale should be based on quality and quantity of behavior. Ratings should reflect a balance of both the intensity of the child's positive affect and the relative amount of time positive behavior is shown. A rating of 1 should be given to those children who exhibit no positive affect and give no evidence of feeling good. A rating of 2 should be given to children who are content during the observation period and who may show perhaps fleeting indicators of positive affect. A score of 3 is appropriate when a child displays more positive affect than just an occasional smile, laughs, and exhibits enthusiastic playfulness, smiles and laughter more than just a few fleeting times, or does so even once or twice for an extensive period. When there is extensive and/or pervasive happy, enthusiastic periods, a score of 4 is called for.

1 = Not at all characteristic. This rating should be given to children who display no signs of positive mood. The child provides no real indication of being happy, content, or even in a pleasant state.

2 = Minimally characteristic. This rating should be given to children who display infrequent or weak positive affect. The child may show brief instances of positive affect, or the child may be characteristically pleasant, content or satisfied throughout the observation period, without exhibiting any strong indicators of positive mood.

3 = Moderately characteristic. This rating should be given to children who frequently display positive affect. The child exhibits several instances of strong positive affect (expresses enthusiasm, playfulness, smiling, and laughter) and is often pleasant.

4 = Highly characteristic. This rating should be given to children who are exceptionally positive, in terms of physical and vocal expressiveness. The child displays multiple instances of strong positive affect and is characteristically "pleasant" for most of the remainder of the observation period. The child should truly "radiate" or "sparkle." For this rating, a child can have no episodes of strong distress.

Negative Mood

This scale assesses the extent to which the child cries, whines, frowns, yells, screams, or tenses body while crying, or otherwise expresses his/her discontentment, anger or hostility. Lack of negative affect may be manifested as either strong positive affect or contentment.

Ratings on this scale should be based on both qualitative and quantitative assessments.

1 = Not at all characteristic. This rating should be given to children who display no negative affect. There are no signs of strong (intense crying, body stiffening) or weak (whining) negative affect from the child during the observation period. A "1" may also be scored if a single mild fret occurs.

2 = Minimally characteristic. This rating should be given to children who display infrequent or weak negative affect. The child displays brief instances of mild negative affect.

3 = Moderately characteristic. This rating should be given to children who display strong and/or more frequent negative affect. The child displays one or two instances of strong negative affect or is moderately discontented (frustrated, whining) throughout much of the observation period.

4 = Highly characteristic. This rating should be given to children who display high levels of negative affect. The child displays several instances of strong negative affect during the observation period and appears to be rarely contented.

Activity Level

This scale assesses how motorically active the child is during the observation. The rating should take into account these aspects of motor activity: speed (moving fast, whether walking, kicking, or jumping); frequency (spending a lot of time in high energy activities); intensity (how energetic the activity); involvement (tendency to engage in high-energy games and gross motor activities over small motor activities); and a negative reaction to enforced nonactivity (reacting with restlessness).

1 = Not at all active. This rating should be given to children who are noticeably low key, passive, inactive, lethargic.

2 = Minimally active. This rating should be given to children who are minimally active.

3 = Moderately active. This rating should be given to those children who are predominantly active. High-intensity activity occurs a few times or the child is active, but less intensely so for most of the observation session.

4 = Highly active. This rating should be given to children who are overwhelmingly active. The child is constantly moving some body part; something is moving almost all the time, often energetically. The child prefers active games and activities to nonactive ones.

Sociability with Peers

This scale assesses the degree to which the child actively and positively/neutrally (but not negatively) participates in his/her social world with peers. Behaviors which can be considered to indicate sociability include talking to, smiling at, playing with and sharing toys with peers. These behaviors may be initiated by the child, or be responses to peers' signals or initiations. These initiative and responsive behaviors must be construed to have a positive social interactive intent.

Ratings on this scale should be based on both quality and quantity of behaviors. The fact that a child may have negative encounters with a peer should not be considered in making this rating. Therefore, do not lower the score a child would get on positive/neutral sociability with a peer to take into account any negative interactions the child may have had with peers.

1 = Not at all characteristic. This rating should be given to children who display almost no sociability. There is no social play, attempts to initiate interaction, or no responsiveness to peers' overtures. The child seems oblivious to or disinterested in peers; social bids from peers are ignored or rejected.

2 = Minimally characteristic. This rating should be given to children who display infrequent or weak social behavior with peers. Social initiations or responses by the child occur, but they are very infrequent or ambiguous. The child is usually engaged in his/her own activity and seems to generally be uninterested in the other children. Peers must typically be persistent to gain the child's social interest, which tends to be brief and of low intensity (e.g. a look).

3 = Moderately characteristic. This rating should be given to children who display frequent social behavior with their peers. The child initiates and/or responds, but the intensity and frequency of the child's behavior is less than a 4.

4 = Highly characteristic. This rating should be given to children who are very sociable. The child initiates and/or responds very frequently, using a variety of behaviors. There are multiple instances of sustained play in which the child

directing clear, positive signals to other children and/or responding to others' initiations.

9 = No opportunity to observe. No occasions for child sociability were possible.

Sustained Attention with Objects

This scale assesses children's sustained involvement with the world of objects. To be included as involvement with objects is attention paid to books being read by a caregiver or to television only when there is explicit motor or verbal evidence that the child is engaged by these objects (e.g., vocalizing, pointing, clapping hands; thus more than passive attention is required.) The child's attention does not jump from one thing to another quickly. The child spends more than a minimal amount of time focusing on the object he/she is in contact with. When focusing on an object the child really "focuses in." Sustained attention may involve coordinating activities with several objects, as when the child builds a structure out of multiple blocks, or the child coordinates the actions of several play figures. The uninvolved child may appear apathetic, bored, distracted, distressed, or aimless.

The focus of this scale is primarily quantitative. Ratings are based primarily on the duration of interactions with objects, and the overall amount of time spent in these interactions.

1 = Not characteristic. This rating should be given to children who display no sustained attention to objects. The child moves from one thing to another in a nonsystematic way, without seeming

to focus on what the objects have to offer.

2 = Minimally characteristic. This rating should be given to children who can sustain attention for only brief periods or for only a limited proportion of the observation period.

3 = Moderately characteristic. This rating should be given to the child who spends more than the minimal amount of time involved in interactions with things. There are a few extended bouts of focussed attention or brief bouts occur often.

4 = Highly characteristic. This rating should be given to the child who is clearly involved, interested, and focused most of the time. When the child is playing with objects he/she is interested in playing with them and is engaged for extended periods of time. To receive this high a score a child cannot have very frequent short bouts of attention (that might seem to cumulatively add up to lots of focussed attention), but must display truly extended bouts of sustained attention.

Child's Engagement with Caregiver (adapted from Booth, 1991)

This scale assesses the extent to which the child is socially connected to the caregiver. Behaviors indicative of engagement include (a) positive responding to the caregiver's initiation of a play activity (attending to the caregiver's suggestions or demonstrations of an activity and following her lead by adopting that activity of incorporating an offered object into ongoing play); (b) initiating play that includes the caregiver (by offering/showing an object, requesting caregiver joins an activity, etc.); (c) positioning/orienting body toward the caregiver, and (d) sustained attention during interaction or play with the caregiver; and (e) expressions of affections directed to the caregiver. Behaviors indicative of disengagement include (a) active rejection of caregiver's play overtures (by pushing offered objects away, defiance in response to caregiver requests, ignoring the caregiver); (b) engaging in self-occupied play that excludes the caregiver; (c) positioning/orienting the body away from the caregiver.

Ratings on this scale should be based on both quality and quantity of behavior.

1 = Not at all characteristic. This rating should be given to children who display no engagement with the caregiver. Children given this rating seem clearly disconnected and disengaged. They actively reject or ignore the caregiver's efforts to engage them and/or initiate no such efforts on their own.

2 = Minimally characteristic. This rating should be given to children who display infrequent or weak engagement. These children are somewhat responsive to caregiver, but not in a sustained way. Brief periods of engagement may occur. Play appears self-occupied -- typically it excludes the caregiver although active rejection also may be present.

3 = Moderately characteristic. This rating should be given to children who are more engaged with the caregiver than not. The child initiates and/or responds but the intensity and/or frequency of the child's behavior is less than a 4.

4 = Highly characteristic. This rating should be given to

children who are very engaged with the caregiver. The child has a high frequency of initiations that include the caregiver and/or positive responses to the caregiver's initiations. Sustained play with the caregiver is observed.

6. Post Visit Interview and Ratings of the Caregiving Environment

At the end of the visit, ask one caregiver, preferably the caregiver who interacted the most with the target child, and put this ID on the cover of this form (Form 11W). Do not change the answers the caregiver gives you. He/she may contradict herself by saying "yes" to question 1 and then "yes" to several items on question 2. Do not change her answers to make them consistent.

At the end of each day's visit, complete the End of Visit Ratings of overall quality of child care, etc. Base these ratings on your observations during the entire day's visit. Rate up to 3 caregivers who interacted with the target child the most over the course of the entire visit. Put these caregiver IDs in the white space on page 3 of the Post Visit Interview Booklet (Form 11W).

Question 7.

Record your best assessment of the amount of time CHILD was outdoors during your visit.

Question 8.

Record your best assessment of the amount of smoking you observed during this visit.

Definitions:

0 = None

1 = A little - Observed only one cigarette smoked in outdoor setting.

2 = Some - Observed one cigarette smoked near child's face (within 3 feet) or several cigarettes smoked at a distance (>3 feet from face).

3 = Moderate - More than 1 cigarette smoked near Child/s face.

4 = A lot - Air is smoky during most of the visit.

Overall positive relationship between caregiver and child (love/attachment) Complete this rating for the caregivers for whom you made Qualitative Ratings.

Caregiver is positive, affectionate to child -- to target child in particular, not just any child -- and child uses caregiver as source of comfort, someone with whom to share experiences.

There is a loving relationship between the two. "Love" is difficult to observe; it must be inferred on the basis of everything that occurs over the course of the observation, including mutual attentiveness, closeness of physical contact, tenderness, responsiveness, and care. The frequency of mutual positive regard, the caregiver's patience and sensitivity, and the intensity and tenderness with which all of these are expressed are all involved. The relationship may be expressed in exuberant actions such as snuggling and cooing or gentle ones such as quiet reassurance or warm holding and whispering. It is not pride, as in showing off the child to others, or the habitual smile used as a defense against apathy; rather, it is an spontaneous expression of strong (mutual) attachment.

1 = no evidence of a special loving relationship; caregiver never singles out the target child for special attention or affection; child indicates no preference for caregiver

2 = hints that a positive relationship may be developing, some evidence of positive feeling, but minimal

3 = definitely is a relationship but it is not strongly or uniformly positive; it may be ambivalent

4 = clear evidence of a strong loving relationship between caregiver and child

9 = inadequate opportunity to observe/rate -- impossible to judge the nature of the relationship between the caregiver and child because they interacted so little (because of extenuating circumstances, not neglect)

Child-centeredness of care

1 = care is inadequate or barely adequate; what matters is the convenience of the staff. No adult is devoting her full attention to making the lives of the children better.

2 = care is adult centered: toddlers may receive adequate care, be responded to promptly, but this is largely in the service of adult goals. Care is never hostile, rejecting, or inappropriate, but it is also not marked by any special gentleness, respect, appreciation, interest in particular children, etc.

3 = care is somewhat/sometimes child centered; sometimes or some children get good care.

4 = care is consistently child centered. When adults talk to

each other it is about the children. Children are talked about with pride, wonder, appreciation, and concern. When adults care for children, it is with the goal of maintaining or improving their comfort, contentment, interest, etc., rather than with making the adult's experience more interesting. There is marked gentleness in handling, marked pride and affection in tone of voice, marked concern with children's well-being, and clear, concerted efforts to provide children with nurturing, stimulating experiences. This scale refers to the caregivers' approach to all children, in general, not just to the target child. All the children get good care.

Coder's overall impression of child care

This is an overall global rating of the child care observed during the visit, ranging from terrible to excellent. It should be based on the quality of the child's experience, the caregiving provided, and the general ambiance of the setting (including what is happening to other children during your visit).

Maladaptive Behavior Checklist

Code yes or no to each item indicating whether you saw any of the caregiver or child behaviors as described at any time during your visit. Other refers to any other adult present during the visit. Note that only smoking behaviors are recorded in this column. Unless the item specifies "target child," these items for the caregiver apply to interaction with the target child or any other child in the setting. Prolonged blank stare = catatonic. Unconsolability = cannot be consoled even though the caregiver tries everything.

How typical was the day

The purpose of these scales is to try to ascertain whether the day was markedly atypical. Use your best judgment to rate how ill at ease each caregiver was. Indicate your impressions of how much the target child tried to interact with you.

H. Peer Observation

Refer to Chapter 27.2 for a complete discussion of the Peer Observation Procedure.

I. Profile Observation Procedures

1. Introduction

a. Purpose of the Profile

Two instruments are being used to provide a comprehensive room or setting level assessment of the quality of the child care environment. The Assessment Profile for Early Childhood Programs--Research Version (Abbott-Shim & Sibley, 1992) is used for all center-based arrangements; The Assessment Profile for Homes with Young Children--Research Version (Sibley & Abbott-Shim, 1993) is used for formal family day care arrangements (see definition of formal family day care, below). The purpose of each is to allow a program-level evaluation of the child care experience being offered the children in the particular child care setting. The Profile has been developed to capture the human and material climate available to all the children in care. Individual subscales within the Profiles assess the variety of materials and their availability; the opportunity for, and fostering of individual exploration and learning provided by caregivers; the degree and type of program planning; as well as the degree of safety and attention devoted to health issues at the site. The Profile assessments are designed to capture the "big picture", that is, to determine the variety and flexibility of the program, not merely to catalog the environment. They seek to describe the children's experiences during a typical portion of a day both accurately and reasonably.

Within the framework of this study, the Profile is unlike every other instrument that is used to assess the child care settings of the study children in that the Profile instrument looks at the environment and interaction as experienced by all the children in the setting rather than just from the study child's perspective. These two perspectives may differ greatly, and it is precisely this difference that we are interested in capturing with the Profile. For example, a child who is reticent or anxious about freely choosing activities on her own, may appear more or less anxious in a care setting where individual exploration is allowed and encouraged as opposed to a care setting in which everything is highly structured and restrictive. Therefore, it is extremely important to adopt the setting-level or group perspective when scoring the Profile items. This means taking all children into account even if the group of children varies widely in age.

This shift in perspective, what it means and what it requires of you, should be thought about carefully and discussed with other child care observers at your site. You are trained, certified, and required to maintain reliability for the most part on measures that focus only on our study child and his or her personal relationships with peers and caregivers. This individual, or at most dyadic, view of the qualitative aspects of the care setting is virtually second nature to you by now. So, also, is your skill at recognizing and coding discrete behaviors. Using the Profile requires a wider social frame of reference. A better understanding of how this shift affects you as a coder and the children as a group will help tremendously in understanding the intent of the Profile, this manual, and the function of the Profile in the child care assessment battery.

b. Overview of the Instruments

Both the Assessment Profile for Early Childhood Programs--Research Version and the Assessment Profile for Homes with Young Children--Research Version are observational measures that provide a comprehensive, systematic assessment of quality within a specific child care setting. Each Profile is organized in a series of descending levels of increasing specificity. The highest, or broadest level denotes the program Component to be used. For our 36-month assessment period, the Preschool Component is appropriate. The next level is more specific and focuses on a number of Dimensions (or subscales) within the particular component. These are the headings found in the table of contents within each Profile booklet such as "Learning Environment", "Curriculum", "Interacting", etc. Standards are the general statements within each dimension chart that are bolded and listed by capital letters. Finally, each standard is supported by a list of numbered items known as Criteria. Criteria (also referred to as items) are the concrete procedures, behaviors, and records that exemplify the values and expectations expressed in the Standards. For example, on the first page of the "Interacting" dimension in the center version, the standard reads, **A. Teacher initiates positive interactions with children**. This statement is then followed by four criteria listed beneath this standard which are intended to test that expectation.

Scoring of the Profiles is done at the criteria level. The data needed to score each criterion accurately are collected in one of three ways: (O) for observation, (D) for documentation, and (R) for report. Each criterion is scored by a prescribed method or hierarchy of methods. The "Methods" column on each booklet page lists the method or methods to be used for the specific criterion. If more than one is listed, the first is the preferred method for scoring. The second or third is only to be used if the observer is not able to obtain the necessary information using the preferred methodology. The actual scores for each item or criterion are dichotomous: either "YES" or "NO".

*****Because neither the center nor the home Profile booklets we are using at this 36-month assessment were designed for our study, certain changes and modifications MUST be made to the booklets before data collection is begun. The changes are the same for both versions. The modifications in data collection for the center version are not the same as the modifications for the home version. The alterations are as follows:

For both the Early Childhood Programs & Homes With Young Children Version: Change the "Observations" number column headings, located at the far right of each page from 1, 2, and 3, to O, D, and R.

Change From: To:

Observations						Observations					
1		2		3		O		D		R	
Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No

For the Early Childhood Programs or Center Version Only: Do **NOT** administer the "Scheduling" and "Individualizing" dimensions beginning on pages 7 and 15 of the booklet. Administer all the other dimensions in the original stapled booklet.

For the Homes With Young Children or Family Day Care Version Only: Do **NOT** administer the "Health" and "Scheduling" dimensions which begin on pages 7 and 15 of the booklet. Administer all the other dimensions in the original stapled booklet. **NOTE:** Change the "Safety" dimension "Methods" column to include (R), report, as a second option for coding items, B1, B2, and B4.

c. Addition of Safety/Health Subscale (Center version) and Physical Environment Subscale (Center and Home Versions)

For the 36-month assessment, 17 items tapping "Safety & Health" must be added to the Center version of the Assessment Profile. These items were selected from the original version of the Profile

Assessment for Early Childhood Programs, based on item analyses conducted by Abbott-Shim and Sibley. These items are contained on a separate folded pullout mistakenly placed by the printer in the center of the Home version of the Assessment Profile. Before a visit to a center setting, observers should make certain that a "Safety & Health" dimension pullout has been inserted into the Center booklet they are carrying. There is a typo in the "Methods" column for item, C. 4. Change the letter "I" to "D" for documentation.

In addition, three items tapping the "Physical Environment", not included in either the center or home versions of the Profile booklet, have also been added to the assessment at 36-months. These items were adapted from Wachs, 1986. They are contained on the second page of NICHD Study of Early Child Care, Form 36S-a, Revision 12/17/93, entitled, **THE NICHD STUDY OF EARLY CHILD CARE ADDENDUM TO FAMILY AND CENTER PROFILE**. Page one of this form contains identifying information for this portion of the Profile assessments (see **5. Preparing the Profiles for the DCC**, below for details on sending completed Profiles to the DCC).

Each Profile has been designed to make data collection as unobtrusive as possible within the child care setting. Most items are scored by observation alone or observation preferred. A smaller number of items require documentation. In other words, you must see and review the actual records in order to score the items. These methods are preferred because they let you score the items based upon what you have seen during the visit.

Because certain events or behaviors in some of the items are less frequent in occurrence than others, and thus your chance of observing them during your visit is unlikely, a third method of data collection is available: (R) Report. For these items you may need to speak with the caregivers and/or other program staff and use their report of what happens to score the items. More often, the (R) report option is offered as a second method in cases where it may not be possible for you to observe or document a particular item. In any case, only one choice can be recorded per item to indicate simultaneously whether the item should be scored as a "YES" or a "NO", and how this information was obtained.

2. The Profile in the Child Care Visit

a. When to do the Profile

The Profile assessment, in both center and home settings, is fully administered during the first visit to the child care setting. No items, whether observed or requiring discussion with the provider, should be left for completion until the second day or later.

In order to approximate most nearly the way in which the full Profile is normally given, and to standardize our methods of data collection, all observers must devote 45 minutes of observation time exclusively to scoring the observation items within the Profile booklets. These 45 minutes are to be divided in the following manner across the duration of the first day visit:

Arrival and introductory remarks, (10 minutes)
Profile Observation Time Segment 1, (15 minutes)
ORCE cycles 1 and 2, (44 minutes each)
Profile Observation Time Segment 2, (30 minutes)
Profile Report & Document Items, (10-15 minutes)

ORCE cycle 3, if given, (44 minutes)
Post Visit Interview & Rating of Caregiving Environment

Observers must try to schedule this first day visit during a time period which will yield potentially the most diversified action within a typical care day. Without seeming to suggest activities and without making the caregiver feel either that we expect certain events or that her schedule is lacking in some way, the observer should try to learn as much as possible about a typical day. You might ask her to describe a typical morning or afternoon. You can then make relatively sure that you do not end up outdoors for the entire visit or see only free play or circle time. Sometimes simply moving the start time of a visit by as little as half an hour may assure you of a greater variety of activities during the visit. You want to control as much as possible what you will have a chance to see on your first visit.

When you arrive at the child care setting for the first day's visit, you should spend about ten minutes to introduce yourself and to let the caregiver and the children become accustomed to your presence. Then the observer should spend fifteen minutes exclusively observing and scoring the ongoing activities and care environment for the Profile. The observer should score Profile subscale (dimension) items based upon the immediate happenings during those fifteen minutes. So, for example, if there is not much interaction between the caregiver and the children, it might be an advantageous time to begin identifying numbers of materials for each item in the "Learning Environment" scale or perhaps to score safety items. If there is a lot of interaction, then the observer would be more likely to see instances of behaviors used to score the "Interacting" subscale. Remember, the point is to remain flexible and to pay attention to what the people and setting offer at any one moment during this first observation time segment. This type of action-driven or opportunistic scoring will allow you the flexibility to make the most of the limited observation time you have for the Profile. This period is followed by the completion of the first and second ORCE cycles.

Following the completion of the second ORCE cycle, an additional 30-minute observation period should be devoted exclusively to scoring the remaining observation items on the Profile. During this period, if you see a violation of a health or safety item which you had previously scored as "YES", you may change that "YES" to a "NO".

Observers are permitted to utilize information that they see during the ORCE observations when completing the Profile during this 30-minute observation segment. They may notice, for example, that the caregiver is behaving towards our study child in ways that might give her a "YES" on an interacting item. This information may be used when subsequently rating the "Interacting" subscale for the Profile. During a non-observe time, an experienced observer might observe something that will help score an environmental or safety item later. It is crucial, however, that this overlapping of information be an artifact of the main focus of the observer. In other words, observers should be focussing on the study child during the ORCE and should be focussing on the entire setting/room during the Profile observation times.

After the 30-minute Profile observation period, 10-15 minutes should be taken to complete any items that are scored exclusively by R or D, or those O and D items that have not been observed or documented, **AND** which list R as an alternative method for scoring. This is done by discussing these items with the provider/director. As highlighted below, no items that are indicated as exclusively O (observation) can be completed using reported or documented information. Observation items must rely on purely observational data. If a third ORCE cycle is to be administered because a Peer Observation will be done on the second visit, NO information observed during this additional ORCE cycle may be included in the scoring of the Profile.

b. Where to do the Profile Assessments

As noted above, at 36-months, Profile data will be collected in centers and formal family day care home settings only. No version of the Profile will be used in informal family day care settings or arrangements in which the child is cared for at the mother's workplace when this workplace is not a child care center or a formal family day care home.

It is necessary that you be able to distinguish formal family day care settings from informal family day care settings. The following list of criteria should be used to determine in which family day care settings the Assessment Profile for Homes with Young Children should be administered.

The Profile should be administered in family day care settings in which:

1. The care provider is licensed or has any other government issued credential (e.g., is registered with a state or local agency).

[IF THE ANSWER IS "NO", THEN PROCEED TO 2 OR 3.]

2. The caregiver is NOT related to the study child, there is at least ONE (1) other child in care who is related to NEITHER the caregiver nor the study child, AND, the study child's care is being paid for according to question 38 in the 35-month phone interview.

3. The caregiver IS related to the study child, there are at least TWO (2) other children in care who are not related to the caregiver or the study child. The study child's care need not be paid care. (By related, we mean anyone who would be given a caregiver ID which would have the second digit relationship code of 0, 1, 2, or 3.)

3. Administering the Profile

a. General Procedural Matters

As has been stated, the Profile has been chosen for use in the study in order to take a program-level perspective of the children's opportunities to experience fully all that is being offered within a particular child care setting. It is most important that as child care observers you understand that you are evaluating an overall picture of the "climate of permission" in the setting to be assessed and that you are not to view the task as a mere cataloging of the physical environment. In other words, you could conceivably visit a care setting with what appears at first to be an extremely enriched physical setting only to find that the children are not allowed to utilize the materials freely and thus, in reality, the materials are for show for the most part. The Profile seeks to represent a reasonable--as well as accurate--description of children's experiences during a typical portion of a day at their child care setting.

Observers should understand that given the time constraints within the first day visit, you are being asked to be reasonable and to use your common sense in capturing this block of time. You should have scheduled this visit with as much potential for variation as possible. You should code items which are scored by observation alone or observation preferred, only in the rooms you and the children are in during your visit. Some of the items allow you to score using reported information if you do not observe or document the criteria during your visit. In general, the child's classroom teacher--in the case of centers--will provide the best source for reported and documented data. On occasion, however, some data may need to be obtained from the center director. These questions may be asked following the two observation time segments.

As mentioned above, the Profile allows you to score individual items using three different methods: (O) observe, (D) document, and (R) report. Within those three methodologies there are also definitional cutoffs that allow you to score an item based upon the number of occurrences, or based upon the overall percentage of occurrences. This last percentage-based method is known as the **dominant mode**. In other words, if the criterion or criteria within a specific item happen(s) more often than not, i.e., the majority of the time, then those interactions or events are the rule rather than the exception and thus, predominate. When you are told to score using

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the **dominant mode**, base your response upon this predominant pattern of behaviors or events.

You may be asked to score other items, such as those in the "Safety & Health" subscales, based upon just one occurrence of the criterion. Other items ask you to score based upon "more than one" occurrence of the criterion. Please pay close attention to these distinctions. Finally, some criteria specify two conditions and both conditions are required to exist to score "YES". This is not the case with items which contain "and/or" statements.

4. Clarification of Items

The Profile booklets that you will be using contain definitions for every item of every subscale on the page opposite each scoring page. You should read each item and then each entry under the Clarification of Terms. The rest of this manual section is designed to supplement and clarify (not replace) these definitions. They stem from questions raised at the Child Care Training and from subsequent e-mail inquiries.

a. Assessment Profile for Early Childhood Programs (Center Version)

LEARNING ENVIRONMENT

The Learning Environment subscale measures the setting in terms BOTH of numbers and variety of materials available to explore, and, the overall "climate of permission" to explore. You are asked to measure the richness in terms of numbers of similar and different materials available for exploration. Under Standard A, there is a numerical baseline of 3 conceptually-linked learning materials within the children's reach needed in order for that criterion to be eligible for a score of (O) "YES". If there are fewer than 3 toys or learning tools physically available in the classroom, then code (O) "NO". If the baseline is reached, you are asked to count whether there are 3,4, or 5 or more items available. You must also decide whether or not these materials are "accessible" to the child in the broader sense.

When we are talking about "accessible" in the broader sense of "permission to use without adult assistance", we are looking for a "climate" within the classroom which fosters individual exploration and encourages or allows individual options for activities without the children's having to ask the caregiver's permission each time a particular item or group of items is wanted for use. It should be noted that there is no prescribed order for evaluating these two hallmarks of a "climate of permission" in the learning environment. Again, your observations will be dictated by what is happening at any moment within the particular care setting you are assessing. Remember, however, that you are limited in the amount of time you have for observation and it may not be wise to put off quantifying the learning materials available until you may have seen them used.

You will get clues about this "climate of permission" in a number of ways. You should observe how the classroom is physically laid out. A classroom which fosters the kind of exploration and learning that takes place in such a climate will have toys and materials placed at child level and displayed so that things can be seen, and so that choices are encouraged and more easily made. There is space for one or two children to be alone. In addition, the caregiver allows a child who has finished a group activity early, or who is bored, to select another task or toy to play with by herself. The caregiver lets a child leave circle time or reading time to take a book or building blocks to a table and work with them alone. The caregiver does not utter words like, "It's not time for science now." or "You have to sit until all the children are finished with their project." or "We're reading this book right now, Johnny." or "Now it's time for art." As can be seen in this last example, a caregiver may restrict the classroom climate by telling the children when and what to do as well as when or what not to do. Further, the caregiver does not even have to speak in order to restrict classroom activities. For example, the caregiver who sets up 3 different art projects on three different tables and offers only these choices for activity would be offering a teacher-controlled activity, not accessible art choices.

The examples given above are all implicit signs that a climate of permission may not exist in the classroom. Further signs may be gotten by adequately sampling the daily routine. For instance, by doing all that you can before your visit to learn about the routine of a typical day, you can determine whether free play early or late in the day is only an expediency for the caregivers who must be free to greet or dismiss children and their parents, or whether it is part of the overall characteristics of the classroom or family daycare setting.

There are certain factors which must be kept in mind when determining the overall picture of classroom variation and flexibility. First, children do not have to be engaged with (touch) all the different criteria category materials available to score an item "YES". Second, you may not double code a learning material, i.e., code the same object on two items. E.g., colored pencils could be considered a small muscle/manipulative material and also a language material, but you could only count them for one of these categories, not both. Third, "free play" time is not necessarily the optimal time for observation. It will probably help determine which materials may be played with only with teacher assistance, but may not necessarily let you measure the full extent of flexibility the caregiver allows throughout the day.

Another factor to keep in mind is that there may be times when you see that the caregiver(s) limit only one particular child's movements. This may be necessary because of behavioral problems with that one child. In this case, you would score the "Learning Environment" criteria based upon the permission granted the rest of the group and not upon the special needs of this one child. Fifth, group safety and daily events such as lunch which is determined outside of the caregiver's direct control, do not invalidate a caregiver's previous or subsequent behavior. It is unreasonable as well as being imprudent for a caregiver to allow a three-year-old child to remain inside playing with toys alone when everyone else is going outdoors to the playground. It is not possible to ask kitchen staff to reschedule other classrooms to suit the desires of one child. The sensitive caregiver will prepare children for these transitions in advance.

Finally, observers should remember that although we do not score the "Scheduling" dimension items, it is to be expected that caregivers will make efforts to structure a variety of activities across the course of a day. It is all right for them to do this and to move the group through the daily schedule of events. The "Learning Environment" subscale looks particularly for flexibility within this scheduled framework so that individually paced activities and learning opportunities are allowed to occur. Therefore, just because a teacher states that it is "circle time", does not necessarily mean that s/he will not permit individual children to pursue other activities on their own. The scheduled activities provide the scaffolding to allow the children the opportunity to experience events with peers and to allow the teacher to teach social order within a larger social setting. Part of a child's socialization should include learning how, and being allowed to express his or her need to be alone without having to disrupt the peer group in order to do so.

An Example of a Climate of Permission

If you see children play with Legos when they have finished snack early--and no one restricts their use, then you know that you may score the small muscle/manipulative materials item, "YES". This would be true for any of the 10 items in centers, 7 items in the home.

Examples of Ways of Limiting the Climate of Permission

Assuming there are three or more materials within reach of the children:

If you see a child bring out a gerbil to play with, or magnets, and the caregiver says that it is not time for science or not to use those items now, then you would score, "NO" for the science materials item. (A5)

If you see a child get up from the reading circle and get a book to read by herself, but the caregiver insists that she return to the reading circle, you would score "NO" for the language materials item. (A7)

If you hear a child say that he is finished with his glitter project and that he is going to play with the Little Tykes workbench, AND the caregiver says that he has to wait until the others are finished or until after naptime, score the drama/self awareness item, "NO". (A4)

If a child takes out the dominoes and begins to play with them, and the caregiver tells the child from across the room where she is occupied with another child that she must wait until the caregiver can help her use them, then score "NO" to the math item unless you may have counted 4 or more different types of math materials and those others have been used by the children freely during your observation time. (A6) In other words, in cases where you have seen other materials within a criterion used freely, a restriction of one or more items would only result in a "NO" score if the loss of that or those item(s) would bring the number of available materials beneath the baseline of 3 materials.

Thus, you can determine accessibility in the sense of "permission to use without adult assistance" in a number of ways. (1) The child may "touch" (become engaged with) an item and be told it's the wrong time for that particular item. (2) The child may try to leave an ongoing teacher led activity and "touch" an item and be told to return to the structured activity. (Notice that "touching" a toy or material, in and of itself, is NOT an adequate criterion to score "YES", for in these two examples, it helps determine a "NO" coding for items.) (3) The child may say he is going to do something new and the caregiver may say he must wait until another time. (4) A child may be using an item and be told to stop until the caregiver can assist him. (5) The children may be told they have to play with specific toys because it is a scheduled or structured event, such as art time or time to do seat work. (6) The written daily schedule may list certain times for Free Play and you observe that those are the only times when free play is allowed.

After you have coded all items "NO" for which there are fewer than three items in that category, and you have coded those items "NO" which you have seen or heard be prohibited and/or restricted to certain time periods, and after you have coded "YES" those items you have seen are truly available to the children and the children have permission to use without adult assistance, you may still have an item or two which passes the numerical criterion, but for which you have not seen or heard anything which will allow you to score it. For those items, use the dominant mode method to score them. Only in a setting where your items had passed the numerical criterion and you had seen all attempts at "free play" stifled before any child could get to specific materials would you need to score "NO" on a large number of items. This would be done based upon the demonstrated dominant mode of restricted movement or extreme adult-centered care within the classroom.

The following is an example of what you might encounter over the course a visit to a center setting.

1. There were no nutrition items, code "NO" as there are fewer than 3 materials. (A8)

2. There were four art materials in a closed teacher supply cabinet, code "NO" because they are not within reach. (A3)

3. All other items had three or more different materials at child level In open containers and shelves. You now know that these items are within reach and of sufficient number to be considered for permissibility and you would do further observation before coding.

4. Children freely use the small muscle/manipulative materials, the drama/role play materials, the math materials, the language materials, the multi-cultural materials, and there are displayed printed language materials in the classroom, code these six items all "YES". (A1, 4, 6, 7, 9, and 10)

5. You have seen a doll with buttons, zippers, and snaps. You have seen that there is a child-accessible sink with soap and paper towels in the room. You have seen a dustpan and broom. During the visit you see a teacher take the dustpan and broom and sweep up the sand a child has just spilled under the sand table. The teacher also insists upon operating the water faucets when children wash their hands. Children play with the doll without needing to ask for permission. You would code "NO" for self-help materials. (A2)

6. You've seen no one touch, talk about using, or be told not to use the five science materials which are on open shelves. You would code "YES" for dominant mode. (A5) Of the seven items that are numerically and physically available or accessible, only the self-help items are not permitted to be touched. Also, remember that the art materials are present in sufficient number, but not available. Six of those eight, therefore, are "YES", so code the science items, "YES".

Section A: Code as explained above. Code remaining unanswered items based upon the dominant mode of the other numerically sufficient and accessible items.

Item A2: You may count a child-accessible sink, soap and towel holder as one type of self-help item. Soap alone does not count, because this does not enable the child to wash hands without help. Do not count toilet paper.

Item A7: Books can only be counted as one type of language material.

Item A8: Mr. Potato Head is not considered a nutrition/health material.

Item A9: A visual display of cultural materials may be counted only once, so if two visual displays are present, they only count as one type of material. The predominant culture does not count. Nor do posters of Aladdin.

Sections B and C: Code for dominant mode.

Item B5: Labels must be understandable for 36 month olds. Thus, they must consist of pictures or symbols. They may be accompanied by words, but may not consist of only words.

CURRICULUM

Sections A, B, C, and D: Code for dominant mode unless otherwise indicated below:

Item A1: If you see one instance of this, code "YES".

Item B6: To get a "YES", the teacher must encourage children to think beyond factual, right answers. For this type of question, there is no right answer or there are multiple solutions to the question. If this occurs more than once during teacher-led questioning, code "YES".

Item B7: Singing does not count as a language activity, unless language-learning is the focus of the song, e.g., singing the alphabet song while pointing to letters.

Item C1: If you see one instance of this, code "YES".

Item C2: If you see one instance of this, code "YES".

Item C4: If you see one instance of this, code "YES".

Item D1: This item addresses the "match" between an activity and the child's level of skills development. Therefore, group "story time", even if the book is focussing on learning numbers, would not count as it is unlikely that the entire group is at the same skill level.

Item D5: If you see one instance of this, code "YES".

INTERACTING

Sections A, B, C, and D: Code as dominant mode, unless otherwise indicated, below.

Item A3: If you see one instance of this, code "YES".

Item A4: If you see one instance of this, code "YES". In this case, the teacher must share information about his/her own experiences, ideas, plans. It does not count if s/he just asks the child about the child's experiences.

Item B3: If you see one instance of this, code "YES".

Item C5: If you see one instance of a negative verbal response, code "NO".

CENTER SAFETY AND HEALTH PULLOUT

Sections A, B, and C: For all "Safety & Health" items, if one example of an unsafe practice is observed then record the item "NO". Only one hazard need be present for the item to receive a "NO", unlike the dominant mode method used in other subscales. When in doubt, code an item as unsafe. Take into account the actual ages of ALL of the enrolled children in the classroom, and rate the environment accordingly. You will need to ask the provider to tell you the ages of any children who are absent on the day of your observation.

Item A3: For children under 2 years of age, toys with a diameter less than 1 3/4 inches are dangerous items.

Item A4: This item does not ask the observer to assess the quality of the written evacuation plan.

Item A5: Grass and dirt do not constitute absorbing surfaces.

Item B1: A minimum of 10 seconds of soap and running water is necessary; alcohol wipes may NOT substitute for soap and water.

Item B2: See B1.

Item C5: Disinfect solution should be 1/4 cup household liquid chlorine bleach and 1 gallon tap water. Solution should be prepared daily.

PHYSICAL ENVIRONMENT (from T. Wachs)

Entire Subscale: Code item 1 if even a single designated space is present. Code items 2 and 3 for dominant mode.

b. Assessment Profile for Homes with Young Children

SAFETY

Sections A, B, and C: For all "Safety" items, if one example of an unsafe practice is observed then record the item "NO". Only one hazard need be present for the item to receive a "NO", unlike the dominant mode method used in other subscales. When in doubt, code an item as unsafe. Take into account the actual ages of ALL of the enrolled children, and rate the environment accordingly. You will need to ask the provider to tell you the ages of any children who are absent on the day of your observation.

Item A2: If you need to ask the provider how and where dangerous items are secured and stored, you are asking permission to see the location, not to report whether or not the items are secured and stored. You would then go to the location and make your own judgement by observation.

Item A3: Heaters need to be protected even if you visit during the summer.

Item A5: Code "YES" if smoke detectors are present on each floor that you visit, with no more than 40 feet between them. You will not be able to test if they are in working order, so disregard this requirement.

Item A9: Includes indoor and outdoor stairs that are accessible to children.

Item A11: Exclude manual dishwashing liquid. See clarification about what asking permission means under A2 above.

Section B: **IF YOU DO NOT OBSERVE ITEMS 1-4, YOU MAY RECORD REPORTED DATA. THIS IS THE ONLY EXCEPTION TO THE GENERAL RULE THAT OBSERVATION ITEMS MUST BE OBSERVED, AND CANNOT BE CODED BASED ON REPORT OR DOCUMENTATION.**

Item B1: Grass and dirt do not constitute absorbing surfaces.

LEARNING ENVIRONMENT

Sections A and B: Code for dominant mode.

Section C: Reread the section Learning Environment, Center Version, pages 177 through 185. Code the items in the Home version the same, except for counting the number of materials within categories beyond the baseline of 3 items.

Item C2: Books can only be counted as one type of language material.

Item C3: You may count a child-accessible sink, soap and towel holder as one type of self-help item. Soap alone does not count, because this does not enable the child to wash hands without help. Do not count toilet paper.

CURRICULUM

Sections A, B, and C: Unlike the center version, code every item in these sections as "YES" if you see it occur once.

Item A6: To get a "YES", the teacher must encourage children to think beyond factual, right answers. For this type of question, there is no right answer or there are multiple solutions to the question. If you see one instance of this during teacher-led questioning, code "YES".

INTERACTING

Sections A, B, C, and D: Code as dominant mode, unless otherwise indicated, below.

Item A3: If you see one instance of this, code "YES".

Item A4: If you see one instance of this, code "YES". In this case, the teacher must share information about his/her own experiences, ideas, plans. It does not count if s/he just asks the child about the child's experiences.

Item A5: If you see this occur with more than one child, code "YES".

Item B3: If you see one instance of this, code "YES".

Item C5: If you see one instance of a negative verbal response, code "NO".

PHYSICAL ENVIRONMENT (from T. Wachs)

Entire Subscale: Code item 1 if even a single designated space is present. Code items 2 and 3 for dominant mode.

5. Preparing the Profiles for the DCC

Directions which apply to both the Center and the Home Versions will be given first. Directions about how to send the separate "Safety and Health" pullout with the rest of the center data will be explained afterwards.

Instructions for Both Center and Family Profiles:

1. Write the Child ID number on the Profile booklet cover. You may want to write the RA number and the date of the assessment, too. Be sure that this information is indicated in some form on the Xeroxed sheets you keep at the site as well.

2. Attach a DM-I (generic cover sheet) to the Profile booklet. In the box marked "FORM/INSTRUMENT", write in "Profile (36R)" for the family Profile, and "Profile (36S)" for the center Profile. Place the arrangement/center ID number on the DM-I where it asks for the caregiver ID. This is a room level assessment and the data refer to the larger setting, not the caregiver.

3. Complete the 36-Month Profile Self-Monitoring Form, Form 36T, and send this with both Center and Family Profile data.

Instructions for Sending the Addendum to Family and Center Profile, Form 36S-a, Revision 12/17/93 with other Family Profile Data:

Complete page 1 information and send with Profile booklet and DM-I form.

Instructions for Sending the Addendum, Form 36S-a, Revision 12/17/93 and Profile "Safety & Health" Pullout Items with other Center data:

Staple the "Safety & Health" Pullout Items to the "Addendum" Form 36S-a so that page 1 of the "Addendum" can serve as the cover sheet to both of these forms. For your site copy, write the Child ID number on the "Safety & Health" pullout. Send this with the Center Profile booklet and DM-I form.

J. H.O.M.E. Inventory

1. Introduction

The Child Care H.O.M.E. is based on the original forms of the Home Observation for Measurement of the Environment (H.O.M.E.) constructed for use in the home setting. The H.O.M.E. is a standardized instrument designed to assess the quality and quantity of support and stimulation provided to the child in a home environment. It assesses the physical (toys and learning materials) as well as the social (responsiveness and emotional support) aspects of such environments. The H.O.M.E. is administered using a combination of observation and interviewing techniques. It should be administered while the child is present and both awake and alert. A binary method of scoring is employed. The Early Childhood version of the H.O.M.E. is used with children 3-6 years of age. There are 55 items clustered in eight subscales: Learning Materials (Items 1-11); Language Stimulation (Items 12-18); Physical Environment (Items 19-25); Responsivity (Items 26-32); Academic Stimulation (Items 33-37); Modeling (Items 38-42); Variety (Items 43-51); and Acceptance (Items 52-55).

a. The Child Care H.O.M.E. Inventory

The Child Care H.O.M.E. was adapted to provide a comparable measure of the stimulation and support provided to a child in the child care home setting. Items for the child care version were constructed to meet the same criteria as items in the home version. The wording of the child care items was changed, but the intent remains the same. Three items were added to the 36 Month version of the child care H.O.M.E. to help depict elements particularly important to child care settings. They are items 48, 49, and 54. The child care version of the Early Childhood H.O.M.E. contains 58 items clustered in eight subscales: Learning Materials (Items 1-11); Language Stimulation (Items 12-18); Physical Environment (Items 19-25); Responsivity (Items 26-33); Academic Stimulation (Items 34-38); Modeling (Items 39-45); Variety (Items 46-54); and Acceptance (Items 55-58).

b. Assuring Validity of the Child Care H.O.M.E. Inventory

The Early Childhood Child Care H.O.M.E. Inventory is being used as a component of the 36 month child care visit. It is being used to supplement information obtained from the Profile, the ORCE Behaviorals and the ORCE Qualitatives. Fifty-five of the fifty-eight items on the Child Care H.O.M.E. Inventory utilize the same criteria as the corresponding 55 standardized items from the original home version of the Early Childhood H.O.M.E. Therefore, it is **extremely important** that this instrument be scored based on the criteria listed in the item definitions for the 36 Month Child Care H.O.M.E.. The H.O.M.E.

was standardized using certain definitions as criteria for "yes" and "no" scores to each item. Observers must use these criteria for scoring the Child Care H.O.M.E. at the 36 month assessment. If not, the data will not be valid. **Observers must not use the definitions for any other instruments or from their own values as criteria for yes/no scoring on the H.O.M.E.** If, at any time, unusual circumstances occur during a child care observation and the child care observer is unsure of how to score an item, that observer may call Dr. Judith Brisby at the Arkansas Site (501-569-3422) for help in determining a score. (It is prudent to gather as many facts as possible in order to present the situation completely, which will result in the most accurate score.)

2. The Child Care H.O.M.E. In The Child Care Visit

a. When To Do The Child Care H.O.M.E.

The Child Care H.O.M.E. is administered on the second day of the child care visit. The procedure is limited to a one and one half hour time period. It is to be started at the beginning of the last ORCE cycle and observations seen during that 45 minute period are to be used to score observation items on the H.O.M.E. Following the last ORCE cycle, the interview portion of the H.O.M.E. is conducted and is limited to no more than 45 minutes -- making a total of no more than 1 1/2 hours for this procedure (45 minutes of observation from the last ORCE cycle and no more than 45 minutes for the interview portion.) (For those situations in which the caregiver refuses to be interviewed except when the children are napping, the interview portion of the H.O.M.E. may be given then, but no additional observations may be done outside of that during the final ORCE cycle.) Observers should not collect H.O.M.E. data during any other procedures.

There will be no exceptions (such as counting items #57 or #58 during the first day or at any time outside the 1 1/2 hour period of the H.O.M.E. administration) in the 36 month assessment period. All items must be scored during the 1 1/2 hour time period outlined above. Counting data outside of this time frame would invalidate the instrument.

Observers must not use definitions and/or scoring procedures from any other instrument as criteria for determining "yes" and "no" scores on the H.O.M.E. Only those criteria listed in the Early Childhood Child Care H.O.M.E. item definitions can be used to determine scoring on this instrument. All scores must be derived from information gained during the designated observation and interview period on the second day. Each measure in the NICHD Study of Early Child Care is independent of all others. Each had its own specific intentions and purposes. Each measure will only be useful if it is administered in strict accordance with its particular purposes.

b. Where To Do The Child Care H.O.M.E.

The Early Childhood Child Care H.O.M.E. is administered in alternate care situations which are in home settings. Because the instrument is designed to look at the child's environment in a **home** setting, this instrument is not administered in an office, a laboratory or a child care center. The Child Care H.O.M.E. is to be administered generally in two types of settings (1) care given to the child in the child's own home and (2) care given to the child in someone else's home. The first type includes: the father caring for the child; a sitter coming in to care for the child; a nanny either coming in daily or living-in to care for the child, a grandparent (or other relative) coming in or living-in to care for the child; a nurse coming in or living in to care for the child; and the mother caring for the child while she provides care for other children in her home (more discussion of this situation can be found in the next section). The second type includes: the child going to a grandparent's (or other relative's) home for care; the child going to a sitter's home for care; the child going to a family day care home; and the child going to care in a neighbor's home. Thus the H.O.M.E. is done in any alternate care situation which occurs in someone's **home**.

c. Time Parameters of The Child Care Day

For purposes of asking questions and probing for details needed to score the child care H.O.M..E., it is essential that data be gathered only during that portion of a day devoted to alternate care (here afterwards referred to as the "child care day"). Ordinarily, the child care day will be counted from the time the child arrives in the situation until the child leaves, or from the time the caregiver arrives in the child's home until she leaves. In situations where the father cares for his child, the child care day shall start from the time the mother leaves (and the father assumes the full caregiving responsibility): it shall end when the mother returns. In the event the mother is a caregiver in her own home, the caregiving day will start when the first child arrives for alternate care and will end when the last child (in alternate care) leaves. It is important that child care observers collect data only during the child care day, the home visitors will collect data on what happens during the home day. These are separate environments and must be treated as such for data collection.

d. The Mother As A Care Provider In Her Own Home

At the 36 month assessment period, the Early Childhood Child Care H.O.M.E. Inventory will be administered in homes where the mother provides care for the study child as well as other children. There are two basic reasons for this. First, the home environment and the caregiving environment are two separate situations. It is possible that there are differences in what occurs in each, especially in the areas of responsivity, academic stimulation, modeling and acceptance. Unless these two environments are assessed as separate entities, it will not be known what differences might occur. Secondly, it is probable that, by the time the study child is 36 months old, the mother, who is a care provider in her own home, may also be caring for infants. If so, it is more likely the infant(s) may demand more of her time, leaving less time for interaction with her own child during the child care day. It is important to determine if this occurs and why it occurs (does it depend on the number of children in the alternate care situation, the ages of the children present, etc.). Thus, it is important that the two environments be assessed as separate situations.

3. Administering The Child Care H.O.M.E.

a. The General Purpose Of Administering The Child Care H.O.M.E.

The general purpose for administering the Early Childhood Child Care H.O.M.E. is to give a different perspective on the caregiving environment from the perspectives offered by other procedures used during the child care day. This instrument is designed to look at the caregiving environment from the child's point of view--what the environment offers the child. This last sentence is important. Observers should keep it in mind, as it is the guiding premise upon which cut-points should be based when determining scoring in borderline situations.

b. How The Child Care H.O.M.E. Is Administered

Although the Early Childhood Child Care H.O.M.E. is a systematic measurement of the caregiving environment, it is administered in an informal manner using a combination of observing and interviewing. As mentioned earlier, it should be based on a 1 1/2 hour period during the second day of the child care visit.

c. The Child Care Observer's Role

The child care observer's role is vital in administering the H.O.M.E. It is the observer's responsibility to gather a **complete** picture of the usual circumstances the child is exposed to in the caregiving environment. In order to do this the observer must be thoroughly familiar with the items on the score sheet and all item definitions. In addition, the child care observer should carefully study all training materials provided and should keep abreast of all information (newsletters and updates provided by the DCC; the Arkansas Site: Aletha Huston, coordinator for the 36 month manual; and Deborah Phillips, coordinator of the 36 month child care assessments) that pertains to procedures for administering or scoring the Child Care H.O.M.E.. The observer should then accompany a trained observer on child care visits to become familiar with the procedure. The number of visits depends on the individual observer's needs and abilities. Several practice H.O.M.E. administrations should be done by the trainee, accompanied by an experienced observer. The trainee and the experienced observer should score items separately, then later compare and discuss their scores. The observer should then follow the procedures for certification (detailed later in this manual). Once the observer is certified in the Early Childhood Child Care H.O.M.E., s/he may begin data collection.

It is the child care observer's responsibility to set the stage for the proper mood--one in which the caregiver is at ease, unthreatened, not defensive and thus, open to conversation concerning what the child experiences while in her care. Remember, observers are trying to "see" the most natural circumstances possible--those most nearly like what the child experiences on a daily basis. There are several things the child care observer can do in order to arrange the atmosphere so this can happen. These include:

Be Totally Objective - It is important that the observer in no way show her approval or disapproval of anything the caregiver says. All mothers, caregivers and child development experts think what they do and believe concerning child care is correct. Observers should avoid conveying their feelings in any way. Observers should be careful not to ask for information in a leading manner, not to share their views in personal conversations and not to mark the score sheet in a manner which would make the caregiver think she had said something wrong. (This can occur by the observer asking a question, getting an answer and then quickly marking the score sheet.)

Speak the Caregiver's Language - The child care observer must gear her language level to match that of the caregiver. It is insulting to talk down to a caregiver, but it is also insulting to use technical terms with which the caregiver may not be familiar. Usually, a few minutes into the visit, the observer can gauge the caregiver's language abilities and comprehension then appropriately match it.

Use Good Body Language - How a person speaks with her body can, in many ways, be more telling than what she says. There are a few basic things an observer can do to avoid conveying the wrong thing. They are: Don't raise your eyebrows at something the caregiver says; don't let your eyes widen at something the caregiver says or does; don't smirk; never sit where your eyes are above the caregiver's (where you would have to look down on her--yours may be lower or level with hers, but looking down on her gives a psychological feeling of being beneath you); match your body posture to that of the caregiver (lean back if she does, lean forward if she does); never fold your arms over your chest (it makes you appear to be closing yourself off from the caregiver); if the caregiver sits on the floor, you should sit on the floor also; and always cross your legs turned in toward the caregiver

Be Genuine - An observer should enter the visit process with the attitude that she is going to meet a new friend and discover what that new friend does during the day in caring for this study child. An observer, who can truly be interested in the caregiver and study child as people, will have no difficulty in projecting the elements necessary for the visit to run smoothly. People respond to sincerity--usually by telling you everything you need to know to collect complete, accurate data.

d. Style and Delivery in Administering the Child Care H.O.M.E.

Observers who were employed in this study during previous assessment periods know that there are as many styles of administering the H.O.M.E. as there are people administering it. Each observer should begin to "have a feel" for what works best for her after several practice sessions. Suggestions will be provided on how to approach certain interview items (in the item definitions). However, the observer must determine what works best for her and use that method in data collection. It is possible that she may need to use several approaches in delivery to meet the demands different situations present.

The observer needs to keep several things in mind when working on style and delivery. They are: The observer needs to be at ease; she needs to put the caregiver at ease; the observer needs to ask questions in such a way that the caregiver is not put on the defensive; she needs to ask questions in such a way that the caregiver does not try to "second guess" what she may feel the observer thinks is the "right" or "expected" answer (such as leading questions); and she needs to be accepting of the caregiver and her opinions and behaviors.

Information for scoring the items on the Early Childhood Child Care H.O.M.E. Inventory is gathered in two ways--observing and interviewing. It is the observer's responsibility to determine what is present or what occurs regarding each item. If an item is not observed, ask about it. If an item is discussed and the response is not clear, probe until it is understood. **The child care observer is the instrument,** the score sheet is not the instrument. The score sheet provides only a record of what the instrument found concerning the items listed there. Those items require much more in-depth information in order to evaluate a "yes"/"no" score than just reading/asking them.

The H.O.M.E. assessment is based upon information gathered in the child care setting both from observing (behaviors between the caregiver and the child and physical aspects of the caregiving situation) and from interviewing (the caregiver about certain happenings which normally occur). In the child care visit, at the 36 month assessment period, the observer starts administering the H.O.M.E. by observing during the last ORCE cycle on the second day and the observer may score the H.O.M.E. on interactions between the caregiver and child noted while coding the last ORCE cycle. Interview items should be discussed immediately following the last ORCE cycle and the discussion should be limited to no more than 45 minutes.

It should be reiterated here that the items, as they are listed on the score sheet, are not the only question observers should ask. Often an observer will need to use as many as 6-8 questions or probes in order to accurately score an item. Life is sometimes complicated; people's responses are sometimes hard to interpret. Just asking the item as it appears on the score sheet is often not sufficient data to give a true picture of this child's environment.

All observation items, items which deal with the availability of materials and items which do not contain a qualifier (such as in the past week, so many times a week, etc.,) **must be based on what is seen and is present at the time of the visit** - not what was there last week, the day before, or will be there next month.

e. Observing In The Child Care H.O.M.E.

Thorough knowledge of the items on the H.O.M.E. will help ensure that the observer will look for the items which can be scored from observation alone. In situations where the caregiver says one thing occurs but the observer sees the opposite happen, the observation outweighs the interview. If the observer has received conflicting observation and interview reports, and still has concerns as to which is the most usual occurrence, she should probe further until there is a clear answer.

Certain items on the H.O.M.E. can be scored from **observation alone. They are: Items #15, 17, 19, 20, 21, 22, 23, 24, 25, 27, 28, 29, 30, 31, 32, 41, 51, 55, 56, and 57.**

The following items are usually observable, but may need to be probed to determine their availability to the child and how they are used with the child to meet H.O.M.E. definition criteria for scoring: items #1, 2, 3, 4, 5, 6, 7, 12, and 46.

The following items may be scored from observation alone, but need to be discussed if they are not observed: items #8, 40, and 52.

Observers must remember that all items on the H.O.M.E. need to be covered. However, the opportunity to observe something needed to score an item may not occur. In such instances, the observer will need to discuss the issue with the caregiver in order to score the item.

f. Interviewing In The Child Care H.O.M.E.

Interviewing for items that are not observable must be done in a manner which will elicit the desired information, yet will not cause the caregiver to lie, "second guess", or answer incompletely. Again, as in observing, a complete knowledge of all items and their definitions will be the best preparation an observer can have before attempting to administer the H.O.M.E.

The item definitions will provide some examples of how to pose questions for items. It is important for the observer to remember, however, that their goal is to get enough information on an item to answer it either "yes" or "no" with no qualms. Observers should not be so concerned with subtle wording (or using the exact wording as in the manual or as seen on training tapes) that they gather incomplete data. If you want to know something, ask. If you still do not understand, explain what you do not understand. **But get the information.** Observers must enable the caregiver to give a truthful and complete answer, but be cautious not to lead them into a particular answer.

Before beginning the interview portion of the H.O.M.E., it is helpful to explain to the caregiver that you have some additional questions dealing with what the child does while in her care. The observer should then explain 1) she has a few questions that are being asked of all care providers, 2) she will be marking those as they are discussed, and 3) she will also be taking some notes so she does not forget anything. One requirement of this study is that the observer start the interview process by saying, "We are interested in learning what types of things (child) does while he is here with you. We are interested in the types of toys he plays with, the places you go--just what a typical day is like. One of the best ways to do that is for you to explain what a typical day is like when (child) is here. You may want to start from the time (child) arrives in the morning and just tell me what usually happens." Observers do not have to say these exact words, but should start the interview portion by asking what a typical day is like. It may be helpful for observers to explain that they will be taking notes so as not to forget anything. This may help lessen the caregiver's apprehension of being "scored" or "tested".

The items which must be answered by the **interviewing technique are: Items #9, 10, 11, 13, 14, 16, 18, 26, 33, 34, 35, 36,37, 38, 39, 42, 43, 44, 45, 47, 48, 49, 50, 53 ,54, and 58.**

Observers should remember that the most important thing is to get the information. If the information gathered is incomplete or completely missing, the caregiving situation will not be presented accurately.

g. Scoring The Child Care H.O.M.E.

Scoring for the H.O.M.E. is done using a binary system - "yes" or "no". The situation (caregiver praised the child twice, the child is taken outside for play every day, the caregiver encourages the child to learn colors, etc.) either happened or did not, thus making scoring an easy task. The ease of the scoring task, however depends on a thorough knowledge of the items and their definitions. There are cut-points for "yes" and "no" scores. These must be followed to the letter because they are the ones used when the instrument was standardized. The use of definitions from any other instrument or from an observer's own values will invalidate the data. The definitions and examples in this manual will generally provide enough information for scoring items on the H.O.M.E. However, occasionally an unusual situation arises which presents the observer with concerns about how to score an item. When this occurs, the observer should call Dr. Judith Brisby at the Arkansas Site. Dr. Brisby will discuss the situation and help you determine appropriate scoring. Observers may also call at any time for further clarifications.

h. Completing the Child Care H.O.M.E. Form

The H.O.M.E. score sheet should be marked with a "+" for yes scores and with a "-" for no scores. These marks should be placed in the square beside the item it represents.

All items should be scored, checked, and double checked before leaving the care situation. Checking to be sure that you have enough information to score each item is important because information obtained at a later time is likely to be less accurate. If an observer finds it necessary to call back to ask about something she forgot to ask during the visit, that may result in inadequate information. Always remember that not obtaining enough information will result in a false picture of the caregiving situation.

Observers will want to score H.O.M.E. items depicting interactions between the caregiver and child at the last point of the instrument time frame (the end of the 1 1/2 hours). It is easy to mark a score on one of these interaction items early in the administration and then overlook an interaction which took place at the end of the administration period. Observers should develop a system (of hash marks etc.) to keep track of the number of times interaction occurred.

4. Subscales and Items Definitions

This manual has a definition for each item in the Early Childhood Child Care H.O.M.E. Each item also has examples of both "yes" and "no" score situations. The first two subscales also have dialogues between the observer and the caregiver to give an example of what probing is necessary to accurately assess the intent of the items. (It is usually necessary to ask several questions rather than just read the item as it is worded on the score sheet.) A key is provided at the end of this chapter with scores and reasoning for these interview questions. In subscales #3 through #8 the conversation for each item is not provided. However, for each item some examples of lead-ins are provided. Each observer must develop her own style and techniques. These examples provided are designed to help start that

process.

a. General Intent of the Subscales

There are eight subscales in the Early Childhood Child Care H.O.M.E. They are:

Learning Materials (Items #1-11) - this subscale deals with the toys, books and games which facilitate learning. (It contains some items that deal with the adults in the caregiving environment and their commitment to their own learning - in effect, adults serve as models as well as providing direct instructional experiences)

Language Stimulation (Items #12-18) - this subscale deals primarily with the caregiver's attempts to encourage language development through conversation, modeling and direct teaching.

Physical Environment (Items #20-25) - this subscale deals with the items which describe the physical environment in regard to safety, space, and appeal.

Responsivity (Items #26-33) - this subscale deals with the caregiver's emotional and verbal response to the child and describes the warmth of that relationship.

Academic Stimulation (Items #34-38) - this subscale deals with the caregiver's involvement with the child's learning, and the caregiver's encouragement of the child to acquire skills and knowledge.

Modeling (Items #39-45) - this subscale deals with the caregiver's role modeling and encouragement directed toward the child's development of desirable and socially acceptable behavior.

Variety (Items #46-54) - this subscale deals with the caregiver's management of the caregiving situation to provide a variety of experiences enriching to the child.

Acceptance (Items #55-58) - this subscale deals with the caregiver's ability to accept and understand a young child's negative and exploratory behavior and her ability to deal with it in an appropriate manner.

b. Item Definitions

Scores and explanations for the probing and interviewing examples for items 1-11 are located after the definition of item #58.

Item #1 - 2 or more toys which teach colors, sizes and shapes are available to the child. These two (or more) toys must afford the child an opportunity to learn about all three areas (colors **and** sizes **and** shapes). No one toy has to offer the child an opportunity to learn all three, but together the toys must make such learning possible. If toys are available which teach one or two of these areas, credit cannot be given for this item. The child must be allowed to play with the toys freely, in his/her own fashion, but the caregiver must also use them to teach these three areas. The caregiver should use the toys to work on all three areas at least once every two weeks for credit to be given. It is the observer's responsibility to determine how the toys are used to teach these things - the fact that a toy is red or a square is not sufficient to credit this item. The toys must be available to the child or must be available to the child most of the times the child asks for them (meaning the caregiver always gets the toys out for the child when asked, except at nap and meal times, etc.). Examples of such toys are shape sorting cubes, pressouts, mailbox, pegboards, etc. The toys must not be designed for someone younger than the child's developmental age, but they may be more advanced, provided they can be used in some fashion by the child. The caregiver does not have to take the sole responsibility for this task, credit may also be given if another adult in the home or an older child (13 years or older) performs the task.

Scoring Examples:

Example: Caregiver reports having a pegboard, shape sorter, but she never uses them to teach any of these things - Score "No".

Example: Caregiver reports having a pegboard and a shape sorter and that she uses them about three times a week to teach all three of these things - Score "Yes".

Example: Caregiver reports having only a shape sorter which has colors, sizes and shapes. She reports using the sorter to teach colors and shapes and even using the big ball and little shapes to talk about sizes - Score "No" because only one toy is used to do this.

Example: Caregiver reports having a shape sorter which she uses for teaching colors and shapes. She reports she has no toys or games to teach sizes but she does use some construction paper cutouts of a bear family. She made the family and made them in different sizes and uses it somewhat like a paper doll set. She made it originally to teach the children social awareness, but has found that it is quite effective in talking about sizes--such as the father bear being big, the baby bear being little, etc. - Score "Yes"

Interviewing and Probing Example:

Observer: I see you have this nice toy that has all these bright colors and places to put the different shapes. I have not seen one of these before. I guess it is kind of like a 3 dimensional puzzle or shape sorter. How does (child) play with this toy?

Caregiver: Well---he tries to fill up all the spaces with the shapes.

Observer: Do you ever help him play with it?

Caregiver: Yes, most of the time he wants me to play with him. Or at least to sit beside him and be the cheering section.

Observer: When you play with him, how do the two of you play with it?

Caregiver: It is usually a give and take play. I put one in and then he puts one in.

Observer: Does he know what the shapes are or the colors?

Caregiver: He knows red, yellow, purple, orange, blue, and I think he is pretty accurate with green now. As for shapes, he knows circles, and has almost mastered squares, but he really hasn't gotten triangles yet.

Observer: Have you ever used this toy to help him learn his colors and shapes?"

Caregiver: Yes, we are using it, because it interests him now. I first used the regular ball shape sorter to get him started on his colors and shapes

Observer: It sounds like he is really making progress. What about sizes? Does he know the difference in big and little?

Caregiver: Yes. He even knows middle size if all three sizes are visible at the same time. (You have one of the two praises you will need for scoring "+" on item #30).

Observer: Do you have any toys, games or learning materials you use to teach sizes?

Caregiver: I have several things, but what seems to hold his interest the most is a set of nesting dolls.

Observer: How do you do that?

Caregiver: I tell him that we are going to take the dolls out. I ask him which is this one and then which one is inside it. Then we repeat the process as we take all the dolls out. The little one is in the big one. This is bigger than this and so on.

Item #2 - 3 or more puzzles are available to the child. These puzzles must have all pieces present. They should be appropriate to the child's age - challenging, yet accomplishable. It is preferable they have more, but the puzzles must have at least 5 pieces each. The key to this item is not whether the child enjoys working puzzles, but whether 3 or more are available to him.

Scoring Examples:

Example: Caregiver reports having 7 puzzles out and available to the child. Each puzzle has 10 or more pieces - Score "Yes".

Example: Caregiver reports having 5 puzzles, two have 9 pieces and the other three have 4 pieces each. All are out and available to the child - Score "No".

Example: Caregiver reports having 8 puzzles. Six puzzles were 12 piece sets, but she doesn't think any except the 3 piece puzzles have all the pieces left - Score "No".

Example: Caregiver reports having 2 twelve piece puzzles. All the puzzles with fewer pieces have been put away - Score "No".

Interviewing and Probing Example:

Observer: Often children of this age enjoy working puzzles (or at least dumping them on the floor), does (child) like to work puzzles?

Caregiver: Not too much of the time. He is not as interested now as he was about 3 months ago.

Observer: Does he have a favorite puzzle?

Caregiver: No, not really. Like I said, he is not too interested in them right now.

Observer: I guess he is just too busy running around to sit still long enough to work them. How many puzzles do you have?

Caregiver: I have about 4 of the puzzles with just 3 pieces for the younger children, but, I guess, I must have about 8 for the older children - the ones with about 8-12 pieces.

Observer: Where are they kept?

Item #3 - Record player or tape recorder and 5 or more children's records or tapes are available to the child. These materials may belong to the caregiver, but they must be available to the child and he must be allowed to operate the record player and/or tape recorder. The tapes and records must be for children. Regular music records or tapes, even if preferred by the child, do not receive credit. A caregiver who reports the presence of these materials but reports that she only lets the children play them at a certain time of the day would not receive credit on this item. (Exceptions such as nap time, meal time, story time, etc. would not result in a negative score.) These materials must be in working order. All tapes and records must be of sufficient quality to be heard and understood reasonably well.

Scoring Examples:

Example: Caregiver has a record player, but the children are not allowed to operate it - Score "No".

Example: Caregiver has a record player and ten children's records and the children are allowed to operate it - Score "Yes".

Example: Caregiver has a tape player and 12 country music tapes, but no children's tapes because the children like these better - Score "No".

Example: Caregiver reports having a record player and a tape player. She also has 6 children's music records, but only 3 are in good enough condition to be heard well enough for the children to sing along. She does have 5 tapes with children's stories that she has recorded herself - Score "Yes".

Interviewing and Probing Example:

Observer: Many children this age are learning to sing and dance. Does (child) like to sing or dance?

Caregiver: Oh yes. All of the children like to do both. We have music hour and try to learn a new song about every two weeks. (Note that you have information to score item #35).

Observer: Do they have any favorite songs?

Caregiver: Yes, they all love that song Barney sings.

Observer: How did they learn about it? Did they hear it on TV or did they learn it from a record?

Caregiver: Well, they first heard it when I got them a Barney video. Then when they liked it so much I bought a tape of just all of his music. There are several that are particular favorites. They like (list songs).

Observer: Does (child) play the tape himself or do you have to operate the recorder for him?

Caregiver: He can do it all by himself now. At first I had to show all the kids how to do everything, but I have a cheap tape recorder so I can let them play the tapes themselves.

Observer: Does (child) just go play a tape whenever he wants?

Caregiver: Any time except when the younger children are taking a nap.

Item #4 - 2 or more toys or games permitting free expression are available to the child. Examples of such materials are: clay; play dough; crayons & paper; paint & paper; finger paints & paper; paste & scraps of paper. Note that paper does not count as one of the toys or games. If the materials available are all in the paint category, it is permissible for the caregiver to keep these put up. In order to receive credit in that instance, however, the caregiver must get them out for the child once a day, **if the child so desires.** The caregiver does not have to take the sole responsibility for this task, credit may also be given if another adult in the home or an older child (13 years or older) performs the task. If crayons & paper, clay, play dough, and/or pasting materials are the toys available, they should be kept available to the child most of the time in order to receive credit. (Most of the time was used here because some caregivers may choose to monitor the use of these materials.)

Scoring Examples:

Example: Caregiver reports the children have clay and crayons and paper available whenever they want to use them - Score "Yes".

Example: Caregiver reports the children have paint, paste, crayons, clay and paper, but they are kept put up and only brought out when the children have been good - Score "No".

Example: Caregiver reports having paint, paste, crayons, clay and paper. The paint and paste are kept on an upper shelf and brought out when the children ask for them. The crayons, clay and paper are out on the 3rd from the bottom bookshelf. The caregiver reports she keeps these things there so the children can go and get them as they want just like the other toys - Score "Yes".

Example: Caregiver reports having all these things, but they are put up to keep the babies out of them. Usually once a week, the caregiver will bring out one of the items for an art project - Score "No".

Interviewing and Probing Example:

Observer: Sometimes children at this age want to do things that really express themselves, in addition to dancing and singing. Does (child) ever like to color, paint, build things out of clay, or anything like that?

Caregiver: Yes, all the children like to color and paint. They are also just getting into pasting. I keep a big box of paper scraps and about two months ago we started learning how to paste.

Observer: How often does (child) do these things?

Caregiver: Well, he colors and plays with the play dough almost every day. He doesn't play with the clay as often. He seems to like the feel of the play dough better. But, I guess he probably plays with the clay 2-3 times a week. And then I get the paste and paper out about 2 times a week--whenever one of the children asks for it. I really get it and some scissors out once a week at a time the children have not asked for it so that we can start learning how to use scissors--I make it into an art project. And that is in addition to the couple of times a week one of the children asks for the paste. (Note that you have received the information needed to score item #49).

Observer: Can (child) get the crayons & paper and play dough any time he wants it?

Caregiver: Yes, it is always kept out on the small table in the corner.

Item #5 - 2 or more toys or games requiring refined movements are available to the child. This item concerns toys which encourage fine motor development - those requiring a certain amount of control in their use. Credit small building materials (legos), train sets requiring assembly, dolls with clothes that can be put on and taken off, crayons & paper, scissors & paper, string beads, etc. These toys and games must be available to the child at all times. Puzzles should not be counted for this item since they are explicitly covered in item #2.

Scoring Examples:

Example: Caregiver reports having legos, different types and sizes of beads to string, crayons, scissors and paper and paste. The legos, beads and crayons & paper are out and available to the child at all times - Score "yes".

Example: Caregiver reports having legos, beads to string and crayons, but they are all kept up because of the small children in the room. The caregiver reports that the toys are brought out several times a month, when the young children are napping - Score "No".

Interviewing and Probing Example:

Observer: Children this age often try to do things that require finer control of their finger movements. Have you noticed (child) doing any of those things recently?

Caregiver: Well, I don't know.

Observer: Does he ever like to build things with legos, color, string beads or anything that really makes him use his fingers?

Caregiver: Oh yes. He builds unbelievable things with the legos. And he can cut with the scissors better than any of the other children.

Observer: Does (child) ever go and get any of these toys and things and just start playing with them on his own?

Caregiver: The legos are the first thing he goes to when he gets here in the morning. And he does get the crayons and color by himself, but that is only a few times a week. I keep the scissors up.

Observer: How often do you find time to get the scissors out and let the children cut?

Caregiver: Two times a week for projects and just when they ask for them. I don't bring them out if I have a baby to feed, but any other time I do.

Item #6 - 2 or more toys or games which help teach numbers are available to the child. Items which would receive credit include puzzles with numbers, blocks, books, games, computer games, dominos, playing cards, etc. Books alone are not enough to credit. Observers may credit one book and one other toy or game. Once again, the caregiver must help the child use these toys for this purpose. And they must be used at least once every two weeks for teaching numbers to receive credit. The caregiver does not have to take the sole responsibility for this task, credit may also be given if another adult in the home or an older child (13 years or older) performs the task.

Scoring Examples:

Example: Caregiver reports having 2 puzzles with numbers. The puzzles both have the same numbers in them - Score "No".

Example: Caregiver reports having one puzzle with numbers, dominos, 2 books with numbers (different books and ways of looking at numbers) and Sesame Street Counting Cards - Score "Yes".

Example: Caregiver reports having 2 books with numbers. The books are different and have different approaches to looking and learning about numbers - Score "No".

Example: Caregiver reports having a book with numbers and a puzzle with numbers - Score "Yes".

Interviewing and Probing Example:

Observer: Does (child) know any of his numbers yet?

Caregiver: Yes, he is counting, or I guess I should say he is trying to count and say the words.

Observer: How is he doing that?

Caregiver: What do you mean?

Observer: I mean do you sit and count with him, do you play games with numbers, like dominos, puzzles, or do you have books with numbers?

Caregiver: Oh yes. We have books and puzzles with numbers. He likes for me to read the number book and guess which number that page is talking about. I think he really knows which number it is now from just looking at the figure. We spend a lot of time doing that. (You have just gotten an answer to item #37.)

Observer: Does he play with any of the other toys or games you have?

Caregiver: Yes, he likes to play with the animal dominos. He will take the counting cards and then match the dominos to the numbers on the cards - or I should say he tries to. He does a good job really. He can match 1-5 correctly each time, but he still has trouble from 6-10. (You have just gotten one of the two you need to score "+" on item #30.)

Observer: Oh, that sounds really exciting. I bet it is a lot of fun to see that.

Caregiver: Oh! It really is. (Child) come over here and show Miss Carol how you match your animals on the dominos to the counting cards. (You have just gotten enough information to score item #32.)

Item #7 - 10 or more children's books are available to the child.

Note that these are children's books. They should be age appropriate or slightly above age level. The books may be shared - they do not have to be the sole property of the study child. They should be in reasonable readable condition.

Scoring Examples:

Example: A 15 page book with only 2 pages left (none of the books really have enough pages to use properly) - Score "No".

Example: 10 Books that are dog eared with only a few small tears where pages are still readable and pictures can still be seen - Score "Yes".

Example: Stories on records and/or tapes do not receive credit on this item unless the target child is visually impaired.

Example: There are 2 golden books present and available and 8 plastic (air filled bath safe) and small hard page books present and available. No other books are available. There are 15 age appropriate books that are kept on the fifth shelf of the bookcase in the caregiving area. These 15 books are brought down and held by the caregiver as she reads to the child. This is done only on special occasions - Score "No".

Example: There are approximately 15 Golden Book type books visible on the next to bottom shelf of a bookcase in the children's playroom - Score "Yes".

Interviewing and Probing Example:

Observer: I know how hectic it can get when you care for children this age. Does (child) ever want you to read to him or does he ever get still enough to look at books by himself?

Caregiver: Well, he likes for me to read to him, but he also likes to look at books himself. I have noticed, just in the past six months or so, that he can sit for 10-15 minutes and really seem totally engrossed in books.

Observer: Does he have a favorite book, or should I say books?

Caregiver: There are two books that he always looks at first, The Three Bears and Barney Goes to the Zoo. He always pulls those two books out when he wants to read or have me read to him.

Observer: Does he ever look at other books?

Caregiver: Oh yes, but those are the first choice.

Observer: About how many books do you have that are for children around his age?

Caregiver: Those two bottom shelves are all books that are for the younger kids.

Item #8 - 10 or more books for adults are visible in the home. The intent of this item is to determine whether the child is being cared for in an environment where reading and having books is valued. The key to this item is that the books are seen by the child as being of value to the caregiver. The books may be a set of encyclopedias, cookbooks, novels, etc. They do not have to belong to the caregiver - they may be library books. Professional journals and high quality magazines such as National Geographic may be counted, but each set may be counted as only **one book.** To be considered in this high quality category, a magazine must be of a reference nature. For example a collection of 3 professional journals of any sort would only count as one book, just as 15 National Geographics would only count as one book. It does not matter how many magazines are in the set, the entire set would only count as one book. The important point is that there are 10 or more books and that they are visible to the child.

If the books are kept in a room other than where the child is normally cared for (upstairs in the living room, etc.), then the child must be allowed to go into that room. The child does not have to go into that room if s/he chooses not to, but s/he must be allowed to enter it whenever s/he wants in order to receive credit. Observers will find instances where the caregiver has arranged her home in such a way that the downstairs portion is devoted exclusively to the child's caregiving and all the adult books are kept upstairs. When this situation occurs the child must be allowed to go upstairs, into the room(s) where the books are kept at least 3 times a week in order to receive credit on this item. For children who are in the care situation less than 3 days a week, they must be allowed to enter the room where the books are kept each day they are in care. If adult books are not visible, the observer should ask about their presence and where they are kept. If the books are stored in a closet, in boxes or in sacks, credit should not be given.

Scoring Examples:

Example: Caregiver reports having books in her bedroom.

The books are kept in the closet. The children are allowed into her bedroom. - Score "No".

Example: Caregiver has 35 journals dealing with child development and 50 books - Score "Yes".

Example: Caregiver has 15 National Geographic magazines, 25 child development journals, 5 journals on safety and 5 books - Score "No". (3 collections of high quality magazines equals 3 books, plus 5 books equals 8 books.)

Example: Caregiver reports having books in her bedroom. They are stored in the bookcase headboard of her bed. The child is allowed into the room. - Score "Yes".

Example: Caregiver reports trading books with friends. Most are kept in grocery sacks to keep them separated by owner. The sacks are stored in a hall closet. The child is not allowed to open or enter that closet. Score "No".

Example: Caregiver reports trading books with friends. Most are kept in grocery sacks to keep them separated by owner. The sacks are stored in a hall closet. The child is not allowed to open or enter that closet. The observer notices 4 books on a table beside the crib area, 2 cookbooks on the counter by the kitchen area and 6 books on child activities on the bookshelf two rows above the children's books. Score "Yes".

Example: Caregiver reports the family has collections of Field and Stream, Readers" Digest, Scientific America, Playboy, Life, U.S. News and World Report, People, Soap

Opera Digest, New York Review, and 6 books - Score "No".

Interview and Probe Example:

A good time to discuss this item (if it is necessary to do so) is when the observer is talking about the number of available children's books (item #7 and about encouraging the child to read a few words (item #38).

Observer: I know how busy you must be. Children this age can be pretty active. Do you ever find time to read yourself?

Caregiver: Not very much. I do read for pleasure in the evening before I go to bed, provided I have all the housework done. I do a lot of reading though when the kids are taking a nap (or should I say when they are lying down - I have a few who do not sleep much). But it is not pleasure reading. I use that time to go through books for ideas for crafts and play activities.

Observer: Do you have many of those kind of books?

Caregiver: I probably have about 6 books with different activities for children.

Observer: I know you mentioned that you read for pleasure in the evenings, do you have your own books or do you go to the library?

Caregiver: I have books of my own, but I also go to the library about once a month.

Observer: About how many books would you say you have, either of your own or counting your own books and library books?

Caregiver: Oh! That is hard to say. Probably around 50 of my own, and that is not counting all of my husband's woodworking books and my teenager's painting books.

Observer: That really sounds like a lot of books. Where do you keep them all.

Caregiver: I keep some down here, so that I can use them for the children activities I plan. I guess there are probably 6 or 8 down here. And I keep 2 or 3 cookbooks down here and usually 1 or 2 novels just in case I get a chance to read a paragraph while they nap.

Observer: Do the children ever get a chance to go into the other part of the house where your other books are kept.

Caregiver: Yes, everyday we go up and look at the fish tank and they take turns feeding the fish. We pass 2 bookcases on the way.

Item #9 - Caregiver reads a newspaper daily in the home. This item is intended to determine the reading habits of the caregiver. The newspaper must be read daily, and in the presence of the child at least once every 2 weeks. The paper does not have to be read in its entirety, but it does require more than looking at the comics and the TV section. The paper can be a Sunday-Saturday edition, but credit may also be given for Monday-Friday papers. Observers should remember that the children need to see the caregiver reading the paper for credit to be given. If care is for less than 5 days a week, the caregiver should read the paper on one of those days the child is present.

Scoring Examples:

Example: Caregiver reports reading the paper before the children arrive - Score "No".

Example: Caregiver reports reading the paper in the evening after the children are gone - Score "No".

Example: Caregiver reports reading some of the paper (she tries to read the front page) while the children are watching Barney on TV - Score "Yes".

Example: Caregiver reports reading as much of the paper as she can when the children go down for rest and nap time. Caregiver reports that the study child sees her reading before she goes to sleep - Score "Yes".

Example: Caregiver does not get (neither buys nor is given) a paper - Score "No".

Interviewing and Probing Example:

Note: Observers will find this item is easily discussed along with item #10.

Example 1:

Observer: I know how busy you must be caring for these children. Do you ever have time to read for your self?

Caregiver: Not while the children are here. I feel looking after them is my job and I should not use that time for reading.

Example 2:

Observer: I know how busy you must be caring for these children. Do you ever have time to read for yourself?

Caregiver: Yes, I try to read when the children go down for a nap.

Observer: What kind of things do you like to read when you get that chance?

Caregiver: I usually only have time to read the front page of the newspaper. And occasionally, if they are tired, I actually get to read the entire front section.

Observer: Is (child) asleep when you start reading the paper or does he see you reading before he drifts off?

Caregiver: He takes about 5-10 minutes to fall asleep. But I don't know if he is watching me read or not. I am in clear view, but I have never asked if he has seen me read it or not. (Score "yes" in a situation such as this.)

Item #10 - Caregiver regularly buys or receives 1 or more magazines. Any magazines would be credited on this item, including children's magazines. The caregiver may subscribe, buy regularly or be given magazines regularly to receive credit on this item. If the caregiver buys a magazine, it should be the same one and it should be purchased on a regular basis. If the caregiver receives magazines from someone else, they should be the same ones and on a regular basis. The Star, National Enquirer, etc. may be counted as magazines.

Scoring Examples:

Example: Caregiver reports subscribing to Sesame Street- Score "Yes".

Example: Caregiver reports buying Ebony every month at the grocery store - Score "yes".

Example: Caregiver reports she does not subscribe or buy magazines because her mother has a beauty shop and she brings over all she has in the shop when the next month's issues come in - Score "Yes".

Example: Caregiver buys the National Enquirer every 3-4 months when she can afford it - Score "No".

Example: Caregiver buys The New Yorker about every other month - Score "No".

Interviewing and Probing Example:

Note: This item can be discussed when the observer is talking about items #9 and #8.

Introduction Example: 1

Observer: I'm sure it must be hard for you to find the time to read when you have children to watch. Do you ever get a chance to read?

Introduction Example 2:

Observer: I know you told me you try to read the newspaper and you have books you read in the evening. Do you like to read magazines?

Caregiver: Yes, I don't have much time, but I do like to keep up with some of the newer ideas that come out.

Observer: What magazines do you like?

Caregiver: I like Woman's Day, Family Circle, Good Housekeeping, and Redbook.

Observer: Oh! Do you get all of those each month?

Caregiver: I buy Woman's Day and Family Circle each month at the grocery store. But I get the others less regularly.

Item #11 - Child is encouraged to learn shapes. (This item is easily discussed when the observer is talking about the items in the Academic Stimulation Subscale #34-38.) For this item to receive credit, the caregiver must make a conscious effort to help the child recognize different shapes and their names at least once every 2 weeks. Someone else in the caregiving environment may perform this task--an adult or even an older child (13 years or older).

Scoring Examples:

Example: Caregiver reports that she holds up different shapes and tells the child the name of each and asks him to repeat it - Score "Yes".

Example: Caregiver reports that she draws different shapes and labels them for the child - Score "Yes".

Example: Caregiver reports that she has started working on such things as "the ball is round", "the box is square", etc. - Score "Yes".

Example: Caregiver reports that she does not have the time, but one of her teenagers does this after school - Score "Yes".

Example: Caregiver reports that she really has not done anything herself because Sesame Street, Electric Company and Barney teach shapes on their shows - Score "No".

Interviewing and Probing Example:

Observer: Tell me, does (child) know any shapes and their names?

Caregiver: He knows round and square and can usually show you something if you ask him. (Child) come here. Show Miss Smith something that is round, you know a circle, like a ball. (Note that this caregiver has just given you information to score item #32.)

Observer: How did he learn to do that?

Caregiver: Well, I really noticed the kids picking up some things as they watched Sesame Street. When that happened, I started working with them by pointing out the round and square objects around the room and talking about them.

Observer: How long has (child) been able to point out these things?

Caregiver: About 3 months.

Item #12 - 2 or more toys that help teach the names of animals are available to the child. There should be two or more toys (in usable condition) present in the home at the time of the visit. Toys which would receive credit include: stuffed animals, toy (plastic or wooden) animals, books about animals, circus games, farm sets, and animal puzzles. The caregiver must use these toys to encourage language development through conversation, modeling and direct teaching. The caregiver must use these toys for the above purpose at least once every 2 weeks. The caregiver does not have to take the sole responsibility for this task, credit may also be given if another adult in the home or an older child (13 years or older) performs the task.

Scoring Examples:

Example: Caregiver reports that there are several different stuffed animals, a farm set, and two books about animals. She also reports that she teaches the study child the names of these when he gets a stuffed toy off of the shelf and when they look at the books - Score "Yes".

Example: Caregiver reports that there are 3 teddy bears and, for the most part, the child learns the names of animals from walks in the neighborhood. She reports the child knows the names of dog, cat, bird and bear - Score "No".

Example: Caregiver reports that she has a farm set and two books of animals, one on zoo animals and one on household pets She says that she uses all of the toys in a direct teaching method and that the study child knows all of the names of the toy animals she has in the home.- Score "Yes".

Example: Caregiver reports that she has a farm set, extra plastic farm animals (because all of the children want to play with them at the same time), animal puzzles, 6 different stuffed animals (a bear, a dog, a cat, a pony, a monkey and a lamb), 4 animal books and a household pet bird. She reports that, other than the pet bird and one of the stuffed animals, all of the toys are kept up so the babies will not choke on any of the pieces. The books are kept up so the pages won't get torn. These toys are brought out a few times a week when the babies are taking a nap. The caregiver reports that she doesn't do anything to help the children learn the names of these animals. They pick up the names from the other children - Score "No".

Interviewing and Probing Example:

Observer: I noticed (child) playing with the little farm animals you have. Is that one of his favorite pastimes?

Caregiver: Yes, he is fascinated with the horses. I believe he will be a cattle man or cowboy when he grows up.

Observer: Well, if he is a cattleman, he may make a lot of money. I'm sure his parents would be happy with that. Does he play with any of the other toys you have that are animals?

Caregiver: Yes, he plays with them all. He seems to like the zoo book and he works 3 of the puzzles all by himself - the pony puzzle, the jungle puzzle and the kitten puzzle. But his favorite is the farm set.

Observer: Does he know the names of all or most of those animals - besides horse?

Caregiver: Oh yes. All the kids have learned the names of almost any animal you can think of from watching the children's shows.

Observer: Do you, or did you, help (child) with any of the animal names?

Caregiver: No, I just let them watch TV and the videos.

Observer: Do you ever have to remind (child) of the name of an animal, such as when you tell him to go get the stuffed bear or when you are looking at a book?

Caregiver: Oh yeah, I do that kind of thing. I thought you meant some real formal teaching thing. I often remind him of what one of the toys is called and also help him by describing one when he seems to have forgotten what a certain animal is. But I don't do any sit down teaching about animals.

Item #13 - Child is encouraged to learn the alphabet. In determining the score for this item, any attempt to introduce the child to letters is acceptable for credit. The caregiver does not have to be responsible for performing this activity alone. Any adult in the caregiving home and/or an older child (13 years or older) may perform the task of helping the child. Activities which would be credited include: teaching the child to print her name; talking about and pointing out letters (in books, magazines, on flash cards, on blocks, etc.); playing with a chalk board; using computer games that deal with letters and/or the alphabet; and singing alphabet songs. Some form of encouragement must be done at least once every 2 weeks for this item to recieve credit.

Scoring Examples:

Example: Caregiver reports that her teenagers teach letters to the study child when they come in from school - Score "Yes".

Example: Caregiver reports that she has several tapes that focus on the alphabet and what some of the letters stand for in song version. She reports they all sing as a group project and then talk about some of the pictures on the wall and what letters they start with - Score "Yes".

Example: Caregiver reports that the child's parents have taught her all of her letters and she really does not have time to do anything like that because of the number of kids she has to care for. The caregiver reports that it takes almost all of her time changing diapers and feeding the little ones and she does not have time to spend with the two older children - besides, they play so well together, she seldom has to do anything with them - Score "No".

Example: Caregiver reports that she just turns on the TV and they have been picking up some letters from the commercials and some of the children's shows - Score "No".

Observers will probably want to discuss this item when talking about the items (34-38) in the Academic Stimulation Subscale. The example below will include an introduction to a discussion of all of these. Each can be interviewed and probed, singly, using the same formula.

Interviewing and Probing Example:

Observer: Tell me, does (child) know any of her letters, numbers, colors, directions such as up, down, under?

Caregiver: Let me see. She knows red, blue, purple and orange real well. And she can sing the ABC song. She completely understands "in", "on", "under" and she is getting better at understanding when things are "behind" something.

Observer: Oh, that sounds exciting. How did she learn these things? Note that the observer's expression of excitement is somewhat leading. It would be better to just ask how she learned to do those things.

Caregiver: Well, the letters we learned mostly from singing songs. And the colors we learned while they were coloring and I kept reinforcing them just talking about different toys, like those we talked about before, and just pointing things out.

Observer: That sounds like fun. Was it hard to teach the ABC song? Or does (child) like to sing anything?

Caregiver: Oh, she likes to sing anything, but all of the kids seem to really enjoy the ABC song. I think they mainly like the melody, but they also get excited when someone tells them they know how to say the ABC's. We have now started trying to just say them without singing.

Observer: That sounds like they are really learning a lot. Are they that good with numbers?

Caregiver: I guess you would say so. All the three year olds can all count up to 6 with no mistakes, but they have trouble after that.

Observer: It sounds like you do some work on numbers while they are here. What do you all do?

Caregiver: We started by just rote counting and then having them do it on their own. Now I have started letting them look at the actual figure and then labeling it.

Observer: That sounds like they are actually reading the numbers. Are they trying to read anything such as their names or other short words?

Caregiver: Well they are not really reading. I have only tried to teach them to find their own names on chairs, papers, etc. I do have some pictures that I have pasted labels on such as "cup", "door" and so forth.

Observer It sounds like you have a really good time here. Tell me how in the world did you teach (child) up and down, under and on top of? That just fascinates me.

Caregiver: Oh! That is probably the most fun thing we do. I remember from having my own children how easy it was. They mainly learned by my telling them to put their toys "in" the box and so forth. I do that with these children also, but, since I knew how easily they picked it up, I developed a game where we put on some music and have a kind of follow-the-leader game of putting our hand "behind" our backs, putting one foot "in front of" the other, etc.

Item #14 - Caregiver teaches child simple verbal manners (please, thank you, I'm sorry). In determining the score for this item, observers must consider not only the verbal manners the caregiver teaches the child, but also the rules and explanations she uses in this teaching process. It is not enough for the caregiver to tell the child to use "please", "thank you" and other forms of verbal politeness, she must also explain why it should be done. This does not have to occur each time, but it does need to occur often enough for the child to learn why the manner should be used and then the explanation should occur often enough thereafter to reinforce that knowledge. A caregiver giving the command to say "Yes, ma'am" is really more in the realm of establishing the caregiver's superior status - not in explaining why such behavior is valuable. Credit should not be given to caregivers who command a child to "say something" and then follow a refusal with punishment. Most attempts to teach manners are acceptable for crediting this item. There should be instruction in several (3 or more) forms of courtesy or politeness for credit to be given for this item. The caregiver does not have to take the sole responsibility for this task, credit may also be given if another adult in the home or an older child (13 years or older) performs the task.

Scoring Examples:

Example: Caregiver reports that (child) has been saying "please" and "thank you" each time she tells her to do so. The caregiver reports that she simply says "say thank you" and makes (child) say please before getting her what she asks for - Score "No".

Example: Caregiver reports that they have circle time each day and discuss certain things that make "nice boys and girls". They talk about when to say please and thank you. And they also talk about what to say when they hurt someone's feelings. The caregiver also reports that she and the children then choose a manner for the week and use it whenever appropriate. They all remind each other when it should be used - Score "Yes".

Example: Caregiver reports that manners are one thing all her charges will use. If they don't say thank you, they are sent to time out - Score "No'.

Example: Caregiver reports that she had really not worked on this until the last 3 months when a parent discussed what they were doing at home with their child. I thought it was a good idea and have been trying to work on the basics such as please, thank you, and I'm sorry. It is really easier than I had thought it would be. All you have to do is supply the word when appropriate and in just a little while all of them are using it. Sometimes they use "thank you "at the wrong times, but they will eventually figure it out - Score "No", because the caregiver did not explain why.

Observers may actually see this occur during the 1 1/2 hour portion devoted to data collection for the H.O.M.E. Even if this occurs the item should be discussed, unless the observer notes the use of three different verbal manners with explanations from the caregiver.

Interviewing and Probing Example:

Observer: Sometimes, around this age, children begin to use simple polite phrases such as "please" and "thank you". Has (child) started using anything like that yet?

Caregiver: Yes, she was saying "please" when she first came to stay with me about 4 months ago.

Observer: So that was something she picked up at home you think?

Caregiver: Yes.

Observer: Does (child) use any other phrases like that?

Caregiver: Sometimes she will say "tank you". I get a kick out of hearing her say it that way. "Please" comes out "peas". It is really cute.

Observer: Does she say anything else besides "please" and "thank you"?

Caregiver: Sometimes, lately, I have heard her say "I tarry".

Observer: How do you think she learned to say "thank you" and "I'm sorry"? Did you work with her on them, help her practice or any thing?

Caregiver: No, her folks are doing all that kind of thing.

Item #15 - Caregiver uses correct grammar and pronunciation. In order to receive credit for this item, the caregiver must be able to communicate in such a manner and with enough precision that she can be be understood by the child care observer. Being able to be understood is more important than the ability to use "The King's English" grammar. Dialectical differences do not result in a negative score, provided the caregiver can be understood. Severe speech impediments would, however. The key to this item is the caregiver's ability to communicate clearly and precisely.

Scoring Examples:

Example: Caregiver speaks in a voice that is loud enough to be heard above the noise of the children present. On several occasions she uses ain't instead of isn't and "they come" instead of "they came". Score "Yes".

Example: Caregiver speaks in a very soft voice which can barely be heard. The child care observer has to ask her to repeat several things that are said in order to hear. The words that are spoken can be understood once the observer hears them. Score "Yes".

Example: Caregiver stutters so badly that some of the intent of what she is saying is lost by the time all of the words are out. Much of the sentence is not completed, due to the stuttering and the observer must guess at some of the verbs that were missed. Score "No".

Example: Caregiver has a hard time in telling the observer what she wants to say. When asked a question, she mumbles and uses a lot of "oh, I don't knows". The caregiver does use fairly good grammar when she gets an entire sentence out, but most of her conversation is disjointed and she jumps from one thought to another, speaking as she thinks. Score "No".

Example: Caregiver is from a foreign country. She is still having trouble with noun and verb agreement, yet the observer can understand what she is saying. The caregiver is very expressive and uses gestures to help with the meaning of what she is saying. The observer and the children can clearly understand her with no misunderstandings. Score "Yes".

Interviewing and Probing Example:

Observer: This item is scored on observation alone.

Item #16 - Caregiver encourages child to talk and takes time to listen. The key to this item is that the caregiver encourages the child to talk. She must do more than simply listen to the child. There must be a conscious effort on her part to inquire about the child's activities and then listen as the child relates them. The caregiver does not have to take the sole responsibility for this task, credit may also be given if another adult in the home or an older child (13 years or older) performs the task. The child care observer may see this occur, but the item must also be discussed.

Scoring Examples:

Example: Caregiver asks each child as s/he comes in the morning what they did the night before and listens to what they say. Score "Yes".

Example: Caregiver asks (child) what she did when she went home last night. The child begins a lively story of going to visit the Easter Bunny at the mall. During the story, the caregiver walks off to turn on the TV and sits down with two other children. Score "No".

Example: Caregiver reports that they have circle time first thing in the morning and each child has time to talk about whatever s/he wants. It may be what they did last night, what they are going to do tomorrow, something they have seen, etc. The other children as well as the caregiver all listen to what each child says. Score "Yes".

Example: Caregiver reports that she spends some time with each child as their mothers bring them to her house. The caregiver reports that she has found it most helpful to get the children to tell her about something they did while the mother is making her exit. She says she has a smoother transition as well as some interesting stories to bring up later for group activities. Score "Yes".

Example: Caregiver reports that she is so busy she rarely has time to listen to the children. Besides, she gets real tired, real fast, listening to all the little mouths going all day. Score "No".

Interviewing and Probing Example:

Observer: I have noticed that a lot of children about (child's) age have started getting excited about what they are doing or have done or plan to do. Does (child) ever come in telling you about her activities?

Caregiver: Yes, she has developed into quite the little chatterbox over the past few months. Her father is in the military and was overseas for several months. Since he came home a few months ago, she has come in every morning with something they did together. She even had him come for show and tell. All of the kids were excited to see his uniform.

Observer: It sounds like she has a lot to say and it sounds like you listen to what the children are telling you. How do you ever find the time to listen to her and the other children and do everything you have to do?

Caregiver: Oh, I just take the time. I think it is important for children to have a chance to share their experiences and to be heard. I start worrying if one comes in and doesn't have any special happenings to relate. That usually only happens when they are sick or getting sick.

Observer: So it sounds like she is always ready to start talking. Do you ever have to ask her if she did anything special the night before?

Caregiver: I did when she first started talking. But now about all I have to do is ask her about something she did the night before (I usually know if she is going to her grandparents house or somewhere) and then we have a big conversation about it.

Observer: Do you find that you have to inquire about her play activities during the day to start a conversation?

Caregiver: I do that more for what she is doing here during the day than I need to do when she comes in the mornings. She gets involved in an activity. Sometimes, if it is something like an art or craft project, I will wait until she has finished, because she becomes so engrossed in what she is doing that I hate to break her concentration. But once she has finished, I always ask her what she has made, brag on it, and ask her why she used a certain color. She seems to be getting better lately about just coming over and telling me what she has done.

Observer: That sounds exciting. I know it must be fun to hear about the things that are important to (child).

Caregiver: Yes. I feel it is really important to listen to them. And I feel it is important that I really get them started in initiating conversations, because I feel that will help them be more independent and self-assured later in life.

Item #17 - Caregiver's voice conveys positive feelings about child. For this item, the child care observer should look for the tone of voice the caregiver uses in talking about the child, as well as what the caregiver says. Observers should look for the caregiver being pleased with the child, proud of the child, happy to have the child around, talking about the child in a pleasant way, talking about the child in a joyful manner, etc. Observers should not be confused by or give negative credit for the caregiver explaining the child's limitations. There is a difference in explaining limits as opposed to explaining all the "bad" traits the child possesses.

Scoring Examples:

Example: Caregiver says she has really enjoyed having (child) in her care. She is always happy and joyful. Score "Yes".

Example: Caregiver says she has had nothing but trouble with (child) and, since she came, she has really led the other children into things they never got into before.

Score "No".

Example: Caregiver says that (child) has been having trouble with learning how to play and share toys with the other children. The caregiver says (child) seems not to be upset when the rules of sharing and playing together are explained and that she goes off to another activity in a happy mood. Score "Yes".

Example: Caregiver says that (child) has terrible temper tantrums that are practically uncontrollable. The caregiver also says that she is seriously considering telling the mother she must find another care situation for the child, because she just cannot handle the hitting, biting, constant crying and most importantly, she does not like the idea that this child has "ruined her happy day care home". Score "No".

Interviewing and Probing Example:

This item is scored from observation alone.

Item #18 - Child is permitted choice in menu, for meal or snack. The key to this item is that the child's wishes receive some consideration. The caregiver does not have to offer or grant a choice at each meal or snack, but some choice on some type of schedule or regular basis should be offered. It may be that each day the child is offered a choice of two different things to eat for lunch and that would receive credit. It may be that there is no choice at lunch, but a choice of two different fruits at snack time, which would receive credit. The choice does not have to be offered on a daily basis. It may be offered weekly, such as each child choosing a food for a snack or lunch, with each child having a turn. But there must be some choice permitted and it must not be on a random basis. There must be some type of schedule for that choice. It should occur no less than once every 2 weeks.

Scoring Examples:

Example: Caregiver reports that every Friday the children make a group decision on what to have for lunch. Score "No".

Example: Caregiver reports that every Friday one child (on a rotating basis where each child has a turn) chooses what to have for lunch and snack that day. Score "Yes".

Example: Caregiver reports that she does not let the children choose either a snack or lunch menu because they would eat nothing but junk all the time. Score"No".

Example: Caregiver reports that, on most days, she has two things she fixes for lunch and that she asks each child which s/he wants to eat. Parents sometimes bring in special treats for the children, but there is usually no choice, except the two things she buys once the caregiver has been to the store. The caregiver always asks the children if they want her to buy this cookie or that cracker for snacks when she goes to the store, but she always gives them a choice of what she thinks is appropriate. Score "Yes".

Interviewing and Probing Example:

Observer: Children this age can sometimes get real picky when it comes to eating. How does (child) do in that area?

Caregiver: She does real well. She will eat almost anything you put in front of her.

Observer: Does (child) ever ask for any certain food, like at lunch or for a snack?

Caregiver: She will always ask for a drink of water when she is thirsty, but that is about it.

Observer: Do any of the other children make requests?

Caregiver: Yes, I have some who have real favorite foods and are much pickier eaters than (child).

Observer: It must be hard when they all want something different. How do you deal with that or what do you say to them?

Caregiver: Well, almost every day I have two things for lunch and I ask them which they want. I pretty well know their likes and dislikes now, so I stick fairly close to those things - within the bounds of reasonably good nutrition. If they keep insisting, I just tell them that I will get some when I go to the store this weekend and we will have it next week.

Item #19 - Building appears safe and free from hazards. Observers should remember that credit for this item is based on definitions which are different from those pertaining to the Profile. Do not use definitions from any instrument other than the Early Childhood Child Care H.O.M.E. to determine how to credit this item. In this item, observers should concentrate on the safety of the building. Things to look for include: plaster coming down from the ceiling; boards missing on stairways; no handrails on stairs; no backboards on stairs; exposed insect or animal traps; raised fireplace hearths; frayed electrical cords; open gas fires; metal space heaters; household cleaners (such as bleach, cleaning fluids, poisons) within easy reach of the child; insects and or rodents running around in the building; lack of screens on upper story homes; etc. In scoring this item observers should be concerned with structural hazards as well as the objects which might cause injury. Overcrowding and clutter in the home does not count as a hazard unless it is so great that it could lead to injury. Obervers should look for the "accidents that are just waiting to happen".

Scoring Examples:

Example: Observer notices no backboards on the stairs. The stairs are leading from the upstairs where the kitchen is located and the children eat, to the den downstairs where the children play. The children must use these stairs daily. Score "No".

Example: Observer notices four stacks of cardboard boxes in the corner of the den where the children play. They contain books. The boxes are stacked within four inches of an open metal gas stove. Score "No".

Example: Observer notices a deck outside the den, where the children play. The caregiver reports that the children play outside on the deck and in the yard beyond. The deck is 4 feet off the ground on the side without the stairs and 5 feet off the ground on the end with the stairs. The railing around the deck is made up of a board at the top and one midway down to the flooring. There is approximately 3 1/2 feet of space between the flooring and the first rail. Score "No".

Example: Observer notices a set of sharp knives in the kitchen in a rack which is attached to the end of an above counter cabinet. There are no chairs or stools in the kitchen and the children are not allowed in the room. They eat in the dining room. Score "Yes".

Example: Observer sees a rat scurry from behind a pile of fireplace wood. Score "No".

Example: Observer steps inside the door to the home and, as she does, she feels the floor give under her foot as if the boards were about to fall or break. Score "No".

Example: Observer sees the caregiver's husband come into the den where the child is playing, and set his paint thinner on the table. He leaves the room several times for one reason or another, leaving the paint thinner on the table. Score "No".

Example: Observer sees the grandfather's hunting equipment (gun, knife in its sheath, and ammo vest) lying in the corner of the den. Score "No".

Interviewing and Probing Example:

This item is scored on observation alone.

Item #20 - Outside play environment appears safe. In order to accurately assess this item, the observer must first determine where the child plays when outside. The outside play area does not need to be adjacent to the home, but it should be within a very short walking distance, such as a block or two. If there is no outside play area available, score "no". (Observers will note this stipulation is opposite that found in the Profile.) The observer should use good judgment when scoring this item. Once again the key is to look for accidents waiting to happen. Things to look for include: broken glass; rusty metal lying around; junk cars and/or piles of debris in the yard or along the side of the street; open ditches or a house so close to the street a child could not safely play in the yard; boards with nails sticking out of them; drug paraphernalia thrown into the yard or the side of the street next to the house; broken or unsafe play equipment; limbs of trees that are rotten and ready to fall; piles of lumber or firewood that could harbor snakes, etc.. Observers should look for all of these things on the path the caregiver and child walk if the outside play area is in a park a block or two from the home. It is wise to walk or drive that route after the visit to accurately assess the situation.

Scoring Examples:

Example: Observer notices a broken bar on the metal swing set. It is sticking out at such an angle that a child running could easily suffer severe injuries to the head and neck area if the bar were hit. Score "No".

Example: Observer notices a pile of firewood that is about 4 feet high. In some areas of the country that is a good place for spiders and snakes (including poisonous varieties) to nest. The children are allowed to play in the area and even on the logs. Score "No".

Example: Observer is told that the children have to go 2 blocks to the park to play. After the visit, she drives the route to the park. She notices drug users on the sidewalk and even sees used syringes at the curb. Score "No".

Example: Observer is told the children play in a common yard area in back of the apartment building. They use the same stairway the observer used coming into the building. The observer noted that, although the stairs appeared to be sound, the handrail was so wobbly she was afraid it would not be strong enough to break her fall, let alone stop it. Score "No".

Interviewing and Probing Example:

This item is scored by observation alone, once the observer has determined the play area and the route taken to get to it.

Item #21 - Interior of the caregiving home is not dark or perceptually monotonous. Observers must use their judgment in scoring this item. They must not, however, base scoring on a completely middle class sense of style. Observers should, rather, look for efforts to liven up, lighten up, and generally make a home more attractive. Things to look for include: good lighting, open drapes, pictures (these may even be something cut from a magazine and unframed) or plants (may be artificial); children's art work displayed; learning materials on the wall and tables (ABCs, bulletin boards, posters). Very little furniture and everything in the room of the same general color would receive a score of "no." Almost any effort to make the home attractive would receive credit. Observations should be based on the rooms the child is allowed to enter.

Scoring Examples:

Example: Observer sees no pictures, posters or wall decorations of any kind in either of the 2 rooms used for the care of the children. Score "No".

Example: Observer notes that the home appears to be very poor, yet the caregiver has the curtains open, lamps lighted because of the cloudy weather, and has even put up two pictures that appear to have been cut from a magazine. The pictures are hung unframed. Score "Yes".

Example: Observer has trouble seeing her forms because there are no lamps on and all of the curtains are closed except one. Score "No".

Example: Observer notes that, although the walls are painted in a beige color which closely matches the furniture (even the wooden children's furniture), the caregiver has hung posters, ABC charts, has made sort of displays of some of the children's books, and even arranged the stuffed animals in an interesting display. Score "Yes".

Interviewing and Probing Example:

This item is scored on observation alone.

Item #22 - Neighborhood is aesthetically pleasing. In this item the child care observer is looking for general pride in the neighborhood. The area may be in one of the poorer sections of town, where the houses are old, but if the residents have maintained the homes in reasonable condition and kept the yards clean, credit can be given. Garish, unsightly and/or dilapidated housing would receive a "no" score. Observers should look for the following things: trees; grass; mowed lawns; clean sidewalks; no boarded-up buildings; no junked cars; no drug addicts loitering across the street; debris and garbage cans not present (except on trash pick-up day); abandoned buildings, etc. It is not absolutely necesary that the neighborhood have grass and trees, but it is essential that efforts have been made to keep the area clean and pleasant to view.

Scoring Examples:

Example: Observer notices the house across the street has big pieces of paint peeling from it and two old rusty cars sitting in the yard between the house and the neighbor's fence. Score "No".

Example: Observer notices all the homes seem to be in good repair and the whole block seems to have flowers blooming. Score "Yes".

Example: Observer notices that all homes appear to be in good repair, the yards have trees and grass and shrubs, but two houses down and across the street, there is an abandoned building that has been boarded up and the yard has not been cut for several months. Score "No".

Example: Observer notices that all the homes in the area are older, but have no peeling paint. It is winter and there is no green grass to be seen, but there are leafless trees and it appears that the yards are kept up. Score "Yes".

Interviewing and Probing Example:

This item is scored from observation alone.

Item #23 - Caregiving home has 100 square feet of space (playing, eating, napping) per child. In determining the scoring on this item, the observer may use the simple rule of thumb of a 10 x 10 or 9 x 12 room as being about 100 square feet. Observers may count only the areas used for care, such as the indoor play area, classroom area, eating area, and napping area. Although this is an observation item, it may be necessary to ask the caregiver which rooms are used for care and how many children are enrolled.

Scoring Examples:

Example: Observer notes that the children are cared for in a downstairs den that is approximately 15 x 25 and they are not allowed into any other areas of the home. There is a bathroom just off the den that is 3 x 3. The children eat in the den at small tables brought out for meals and they nap there on mats which are usually stored in the cabinets by the fireplace. There are 6 children in care in this home situation. Score "No".

Example: Observer notes that (child) is cared for alone by the nanny, who comes in every day. The child primarily plays in the den, but may also go upstairs to his room to play. The den is 15 x 20 and the bedroom is 12 x 15. Score "Yes".

Example: Observer notes there are 7 children in this care situation. They are allowed to play in the playroom which is 12 x 12, in the den which is 12 x 12 and they eat in the kitchen which is 9 x 12. They nap in the den. Score "No".

Example: Observer notes that (child) stays with his aunt and cousin. They play in the family room and eat in the kitchen area. They use the bathroom off of the family room. The family room is 15 x 20 and the kitchen is 10 x 10. Score "Yes".

Interviewing and Probing Example:

This item is scored by observation alone.

Item #24 - Rooms used by the children are not overcrowded with furniture. Observers should determine if the furniture is arranged in such a manner that there is room for the child to play and that exits are not blocked. Again, the observer's sense of style is not what is at issue here. What is important is that rooms are not so crowded with furniture that children cannot engage in reasonable amounts of play and get in and out of doorways without stepping around or over or having to move furniture. Too much crowding increases the likelihood of injury and reduces the amount of exploration.

Scoring Examples:

Example: Observer notices that there is a large area for play. The children's tables and chairs are moved to one end of the room, forming a classroom effect. Adult furniture is sparse and moved to the walls in the room allowing a play area for the children in the center. Score "Yes".

Example: Observer notices that all furniture has been moved to the walls forming a play area in the center of the room. The sofa covers the door to the back yard. Score "No".

Example: Observer notices the only adult furniture is one straight chair and one rocking chair. All other furniture is child sized and it is in one end of the room, in front of the window. The rocking chair is over by the baby bed and the straight chair is placed at the counter separating the care area from the kitchen which is used only for child care. All doors are free of furniture . Score "Yes".

Example: Observer notes that in a 12 x 15 room there are two adult sofas, three arm chairs, two children's tables with four chairs each, a big screen TV, three endtables and one coffee table, a baby bed and a pile of sleeping mats. Score "No".

Interviewing and Probing Example:

This item is scored by observation alone.

Item #25 - Caregiving home is reasonably clean and minimally cluttered. For scoring on this item, observers will have to use their good judgment. Hospital clean is not the standard to use in making a decision. It is perfectly acceptable for toys and materials to be scattered around the play area. If a meal has just been completed and there are dirty dishes not yet washed, credit should be given. However, clearly unsanitary conditions would receive "no" scores.

They would include such things as: roaches, ants, rats/mice, food on the floor (not that the children have just spilled, but rather food that has been there for a few days/weeks), stacks of dirty dishes (again not just those that have been placed there to hold until you leave and they can be dealt with), sacks of old garbage sitting around, clothes or newspapers strewn across the floor or left piled in a corner, noticeable odors of urine/feces, etc.

Scoring Examples:

Example: Observer must brush roaches off her papers before she can mark answers. Score "No".

Example: Observer notices the strong odor of feces. She is informed that one of the children has diarrhea. The odor is coming from a plastic trash bag sitting in the kitchen. It is so full no other trash could possibly be put in it. Score "No".

Example: Observer enters the home just as the children have finished lunch. One child remains finishing her meal. Two items on the menu were green peas and something with raisins - most of which have landed on the floor. Score "Yes".

Example: Observer enters the home to the unmistakable smell of a child having just vomited. There is an area on the floor with several paper towels over it. The caregiver is comforting a child, wiping her mouth, etc. She asks the observer to come in and make herself at home - there has been a small emergency and she will be with her just as soon as she can get things under control. Score "Yes".

Interviewing and Probing Example:

This item is scored by observation alone.

Item #26 - Caregiver holds child close 10-15 minutes per day. For this item the observer may credit the caregiver holding the child while she is involved in another activity such as watching TV or reading a book. The 10-15 minute period does not have to be done in one setting, it may be broken up into smaller portions of time throughout the day. The key is that the caregiver does spend that much total time holding the child and it should be in a more cuddling fashion, rather than in a "pick them up to keep them out of the way" manner. The caregiver does not have to take the sole responsibility for this task, credit may also be given if another adult in the home or an older child (13 years or older) performs the task.

Scoring Examples:

Example: Caregiver reports that (child) is not much of a cuddler, but does like to be held before napping. She reports that she does not have time to do that because she must rock the babies to sleep. Since that is the only time (child) wants to be held, she does not get held. Score "No".

Example: Caregiver reports that all the children want to be held and rocked. She cannot rock all of them at the same time, but she does take a period in the morning and then again in the afternoon and give each child turns rocking them for 5-10 minutes both morning and evening while the others are involved in free play. Score "Yes".

Example: Caregiver reports that, since (child) is the only one she cares for, there is plenty of time for holding her. She reports holding several times a day for a total of approximately one and one half hours. Score "Yes".

Example: Caregiver reports that she just simply does not have time to hold the kids. That is what makes sissies out of them anyway. Score "No".

Lead-in Examples:

Observer: Even though children are pretty active at this age, sometimes they still want to be held. Does (child) ever want you to hold her?

Observer: It looks like (child) goes ninety miles an hour all the time. Does he ever slow down? When he does, does he ever want you to hold him? Do you get a chance to hold him? About how long will he let you hold him?

Observer: I see you have two infants here. How do you manage things when all of the children want to be held and cuddled?

Item #27 - Caregiver converses with child 2 or more times during visit. To receive credit for this item, the caregiver must make an effort to converse with the child. Conversing would include such things as asking questions and talking about anything of interest - in other words the caregiver must engage in a verbal interchange with the child. It may be initiated by either, but it must be more than vocalizations, brief directions, rhetorical questions, commands, scoldings and/or accusatory comments. The caregiver does not have to take the sole responsibility for this task, credit may also be given if another adult in the home or an older child (13 years or older) performs the task.

Scoring Examples:

Example: Caregiver asks (child) if she went to church last night. The child replies that she did. The caregiver then asks if (child) went to the nursery or sat in church with her parents. The conversation continues with what songs they sang, if (child) stayed awake the whole time, what dress she wore, etc. The observer notes this type of situation happening 4 times during a two hour period. Score "Yes".

Example: Caregiver (who is the father) is trying to read the paper during a good portion of the visit. During this time the child is asking a great many questions. The father occasionally mumbles an "uh huh". Throughout the allotted time frame, the father never once has any type of give and take conversation with the child. Score "No".

Example: Caregiver asks (child) about her art project as she is doing it and later when it is completed. The caregiver discusses with the child what she might want to do after her nap. The caregiver is approached by the child and they have a conversation about the dog outdoors. The caregiver has a give and take discussion with the child concerning what she and her parents will do that weekend. Score "Yes".

Example: Caregiver and child have one give and take conversation. The rest of the time the caregiver merely answers questions very briefly or gives directions. Score "No".

Lead-in Example:

This item is scored from observation alone.

Item #28 - Caregiver answers child's questions or requests verbally. In order to receive credit for this item the caregiver must make an effort to answer most of the questions asked by the child. If the caregiver is unable to answer at that particular moment, she may tell the child they will talk about it later (look it up later, find out later, etc.). Any response which puts the child off (doesn't answer the question) with no promise of answering later would not receive credit. Examples would include: "Sh-h! I'm talking now.", "I'm busy now, go away.", "Don't bother me now.", etc. If the child makes no verbal request and asks no questions during the data collection time, score "No". The caregiver does not have to take the sole responsibility for this task, credit may also be given if another adult in the home or an older child (13 years or older) performs the task.

Scoring Examples:

Example: Caregiver answered each question asked by the child. Score "Yes".

Example: Caregiver answered less than one half the questions asked by the child. Score "No".

Example: Caregiver responded to most of the child's questions by remarks which were "No, you don't.", "No, you can't.", and "What did I tell you?". Score "No'.

Example: Child did not ask any questions. Score "No".

Example: Child did not ask any questions, but he did make three requests while there. The caregiver responded verbally to each request. Score "Yes".

Lead-in Example:

This item is scored from observation alone.

Item #29 - Caregiver usually responds verbally to child's speech. This item is very similar to that found in the Infant/Toddler version of the H.O.M.E. To receive credit for this item, the caregiver must respond in some verbal way to the child's speech. When the child vocalizes, the caregiver must say something. It can be as little as "Uh huh", "Um", or "sure", but some sound must come out of her mouth in response to what the child says. The caregiver does not have to take the sole responsibility for this task, credit may also be given if another adult in the home or an older child (13 years or older) performs the task. This must occur at least 50-75% of the time for credit to be given (most of the time). The key element in this item is that the caregiver recognizes and acknowledges the child's vocalizations, does not ignore them. Vocal responses designed to quiet or dismiss the child (such as "hush" or "not now while I'm talking") do not receive credit. If the child does not vocalize in any way during the visit, the score would be "no", because there was no opportunity to determine whether a response would have occurred.

Scoring Examples:

Example: Observer notes that almost every time the child says something, the caregiver says something back. Score "Yes".

Example: Observer notes that the child has not said a word that could be heard or intended for the caregiver during the visit. Score "No".

Example: Caregiver answered in some type of vocalization each time the child said something to her. Score "Yes".

Example: Caregiver answered the child's questions only when she was not attending to something else. That occurred in less than one half of the questions asked by the child. Score "No".

Lead-in Example:

This item is scored by observation alone.

Item #30 - Caregiver praises child's qualities twice during visit. This item is similar in intent to the corresponding item found on the Infant/Toddler version of the H.O.M.E. Observers should look for spontaneous praise from the caregiver. If the observer brings up a topic and leads the caregiver into praising the child, that praise should not count as one of the two acts of praise necessary in order to receive credit. Observers may credit spontaneous praise offered by the caregiver regarding the child's looks, clothing, behavior and special skills. These skills may be in the areas of physical, social, cognitive and personal behavior. There must be two spontaneous praises in order to score "yes". Praise may be given to the child as well as told to the observer.

Scoring Examples:

Example: Caregiver says that (child) has the best disposition of any three year old she has seen. She later tells the observer that she knows her colors real well. Score "Yes".

Example: Observer asks how well (child) eats. Caregiver replies that she eats real well. This is the only praise she offers. Score "No". This was in response to a lead-in question by the observer.

Example: Caregiver tells the child that she did a good job of wiping off the table. The caregiver then tells the observer that (child) also can put up the toys all by herself. Score "Yes". Praise my be made to the child and receive credit as well as being told to the observer.

Example: Caregiver tells the observer that (child) can throw a ball farther than anyone else there. She then tells the observer, when asked about picking up toys, that the child does a good job of that. These two praises are the only ones given. Score "No". (The second praise was in response to something you ask and, thus, set-up.) Observers will remember from the Infant/Toddler version of H.O.M.E. that a lead-in praise does not count, but one following would.

Interviewing and Probing Example:

Observer: How does (child) do with eating? Is she picky?

Caregiver: No, she is a real good eater. She will eat anything you put in front of her. **This would not be a spontaneous praise and would not count as one of the two necessary to receive credit on this item.**

Observer: That's great. I know it must make it a lot easier for you.

Caregiver: It really does. And, not only does she eat well, she always cleans up her place at the table without being reminded. **This would be spontaneous praise and would count toward one of the praises needed to credit this item.** She takes her plate and cup to the kitchen and then wipes off the table. **This next statement could, also, be counted as spontaneous praise.**

Lead-in Example:

This item is scored from observation alone.

Item #31 - Caregiver caresses, kisses, or cuddles child during visit. Again, this item is similar in intent to one found in the Infant/Toddler version of the H.O.M.E. - it concerns physical contact designed to nurture or soothe the child. Any kiss and/or cuddle would receive credit. The caregiver does not have to take the sole responsibility for this task, credit may also be given if another adult in the home or an older child (13 years or older) performs the task. Observers must watch closely for caresses as some of these gestures may be very subtle. Subtle caresses which would count would be: stroking a hand, stroking the hair (not fixing it), rubbing a finger or hand, rubbing a foot or knee, patting a portion of the child's body, etc. All of these more subtle caresses receive credit just as the more obvious do.

Scoring Examples:

Example: Observer sees caregiver pat the child on the shoulder. Score "Yes".

Example: Observer notices the caregiver rubbing the child's hand while they are standing in line for the child's turn on the swing. Score "yes".

Example: Observer sees no physical contact between the caregiver and the child. Score "No".

Example: Observer notices three instances of physical contact involving inhibiting the child's movements (such as stopping the child from doing something). Score "No".

Example: Observer sees the caregiver pull the child's hair out of her eyes and fasten with a barrette. The observer notes no other physical contact between the caregiver and the child. Score "No".

Lead-in Example:

This item is scored from observation alone.

Item #32 - Caregiver helps child demonstrate some achievement during visit. Any conscious act of the caregiver to try to get the child to do something to impress the observer would be credited here. It is not necessary for the child to actually demonstrate some achievement in order to receive credit, just that the caregiver ask the child to do something to "show off" or impress the observer. Some examples are the caregiver asking the child to show how she counts, to sing a song, to dance, to say her ABCs, to explain how a toy works, etc.

Most caregivers are proud of the children they care for and are usually anxious to have them show "how smart" they are. The caregiver does not have to take the sole responsibility for this task, credit may also be given if another adult in the home or an older child (13 years or older) performs the task. If the observer asks for the demonstration, credit should not be given. Observers will find that this usually occurs during the discussions dealing with the items in the Academic Stimulation Subscale.

Scoring Examples:

Example: Caregiver asks (child) to "show Miss Leslie how you can hop". Score "Yes".

Example: Caregiver asks (child) to "show Miss Sandra how she can say her ABCs". Of course, the child will not say them at that time. Score "Yes".

Example: Caregiver asks (child) to "show Miss Frances how you can take your shoes off and then put them on again". The child actually does it at that time. Score "Yes".

Example: Caregiver does not ask the child to show the observer how she can do anything. Score "No".

Lead-in Example:

This item is scored from observation alone.

Item #33 - Caregiver allows child some latitude in sleeping arrangements during day. The purpose of this item is to determine whether the caregiver is overly restrictive and demanding concerning naps. It is acceptable that the child is required to rest during the day. The caregiver must, however, allow some leeway regarding when the nap is taken, how long the child must rest, and the physical arrangements for napping in order to receive credit for this item. The observer should probe for all three areas to determine what the caregiver does and determine whether or not she feels enough latitude is offered considering the caregiving circumstances.

Scoring Examples:

Example: Caregiver reports that she allows (child) to nap next to her best friend, provided they do not talk so much that they wake up the sleeping children. There are 15 children in the child care home situation. Score "Yes".

Example: Caregiver reports that she allows (child) to sleep next to her friend and to just lie there and rest (does not have to sleep), but that all the children have to stay down resting or looking at books for one hour. There are 8 children in this home. Score "Yes".

Example: Caregiver reports that because there are so many children in her home (5) she assigns spots for nap mats and the children must lie on their own mats without talking until the last child wakes up. Score "No".

Example: Caregiver reports that she has so many "little pills" she has to assign spots for naps and requires them to lie quietly for one hour and forty-five minutes, but will let any child take a nap at any other time they want. Score "No".

Example: Caregiver reports that most of the children nap after lunch, but that (child) does better if she naps about

2:30. She lets (child) stay up while the others nap and do quiet things such as look at books, color, work puzzles. The caregiver then says that when the child gets sleepy, she goes and gets her own mat and puts it in an out of the way place in the direction she wants it and goes to sleep. The caregiver wakes her after she has slept for 45 minutes, because she and the parents have found that amount of sleep works best all around for (child). Score "Yes".

Lead-in Examples:

Observer: I know children this age are really full of energy. Do they ever wear down enough to take a nap?

Observer: Whether or not the children ever get tired during the day, I am sure you must. Do you ever manage to get them down for a nap? Does that give you a few minutes to sit down and rest?

Observer: With so many children, how do you manage naps. Or do they take naps?

The next 5 items (34-38) are in a subscale which deals with ways the caregiver uses to encourages the child to develop these skills mentioned in each. Item #13 illustrates how these items could be discussed as a group along with #13. Observers should refer back to item #13 for details. Most of these items fit easily into a discussion of the various toys and how they are used that are found in Subscale I.

Item #34 - Child is encouraged to learn colors. Credit for this item may be given for any attempt by the caregiver to teach colors. It is not necessary for the sole responsibility of this item to rest with the caregiver. Another adult or older child (13 years or older) in the home may also perform this task and receive credit. Things which can be included in this teaching process include: pointing out colors while dressing the child; playing with toys (see item #1); looking at books or magazines; discussing colors during arts/crafts projects; while taking nature walks; watching cars go by; discussing colors with flash cards and etc. The key element in this item is that the caregiver is actively helping the child learn about colors. This must be done at least once every 2 weeks for credit to be given.

Scoring Examples:

Example: Caregiver reports that the child has learned all about colors from her parents and that she does not have time to do any work on that during the day. Score "No". (But probe for some of the less obvious methods that the caregiver might not consider formal teaching.)

Example: Caregiver reports that she works with the child on color recognition using flash cards. Score "Yes".

Example: Caregiver reports that they all have circle time and one day a week they go through a routine dealing with various aspects of learning colors such as naming their favorite color, finding something in the room that is that color, and then finding the crayon that is the same color, etc. Score "Yes".

Example: Caregiver reports she does not help (child) learn about colors, but a first grader comes in after school and does those sorts of things while they play "school". Score "No". A first grader is really not old enough to do the type of teaching expected of this item.

Lead-in Example:

Observer: I have seen some children who know some of their colors by this age. Does (child) know any? How did she learn about them? What sort of things do you do to help her learn about them?

Observer: I noticed earlier that (child) was really engrossed in coloring a picture. He seemed to know just which color he wanted to use. How did he learn about colors?

Item #35 - Child is encouraged to learn patterned speech. The intent of this item is to determine whether or not the caregiver is actively engaged in helping the child to learn patterned speech. The caregiver does not have to take the sole responsibility for this task, credit may also be given if another adult in the home or an older child (13 years or older) performs the task. Any attempt to teach the following would receive credit: nursery rhymes, prayers, songs, TV commercials, phrases that are part of some jingle from commercials or songs, etc. Some form of teaching/encouragment must be done at least once every 2 weeks for credit to be given to this item.

Scoring Examples:

Example: Caregiver reports that she has taught each of the children a prayer to say before lunch. They all take turns saying the blessing. She also has group singing each day.

Score "Yes".

Example: Caregiver reports that she does not do any singing with the children, she just lets them pick up what they can from listening to the radio, records & tapes, and from programs on TV. Score "No".

Example: Caregiver reports that she waits until the school children arrive in the afternoon and then lets the 10 and 12 year olds teach the younger children all the songs she has long forgotten. Score "Yes".

Example: Caregiver reports she has a circle where they recite rhymes and then she lets them practice on a tape recorder once they have learned them pretty well. Score "Yes".

Lead-in Examples:

Observer: Sometimes children this age can pick up all the words to the TV commercials on their own. Has (child) done this yet? Then continue with what other patterned speech the child does and what the caregiver has done to help her learn them.

Observer: I know there are a lot of nursery rhymes for little children. Does (child) know any?

Item #36 - Child is encouraged to learn spatial relationships. Credit for this item should be given if the caregiver makes a deliberate and planned effort at least once every 2 weeks to clarify the meaning of prepositions such as: up/down, under/over, big/little, in/out, behind/in front of, underneath/on top of, etc. Credit should also be given if the caregiver tries to teach the child about directions or orientation in space, (left/right, ceiling/floor, in the corner, out the door, across the street). Most caregivers do this without really being aware of it (telling a child to pick "up" the toys and put them "in" the box). The caregiver does not have to take the sole responsibility for this task, credit may also be given if another adult in the home or an older child (13 years or older) performs the task.

Scoring Examples:

Example: Caregiver reports that she has developed an action game in which the children play "follow-the-leader" and do things such as put their hand in front of, stand behind, etc. Score "Yes".

Example: Even after careful probing, the caregiver reports that she has never done anything to help (child) learn any of these things. She guesses (child) just picked it up from the other kids. Score "No".

Example: Caregiver reports that she does not do anything in this area, but her aide has been working on in/out, top/bottom and big/little with (child). Score "Yes".

Example: Caregiver reports that she started having the child pick up her toys and put them in the toy box, but that she placed the emphasis on putting the toys away and not on the "up" and "in". She did say she thought that sounded like a good thing to try. Score "No".

Lead-in Examples:

Observer: Sometimes children this age have a hard time understanding simple commands such as pick it up and put it in - those kinds of prepositions. Is (child) having any problems with those? Which ones does she know? Have you done anything to help her?

Observer: I saw (child) picking up her toys earlier. How did she learn to put them away? I know those commands that require a preposition such as up, in, on, under etc., can be pretty hard to understand. Did you do anything special to help her learn (the ones she knows)?

Item #37 - Child is encouraged to learn numbers. Credit should be given for any attempt to teach the child numbers. This must be done at least once every 2 weeks to receive credit on this item. Examples of such activities which could be credited include: counting toes or fingers; asking the child how old she is; teaching her to hold up a certain number of fingers; pointing out numbers in books, puzzles; using flash cards for number recognition, etc. This can also be done in the context of playing a game (e.g. "move 3 squares", "take 2 big steps", "which one has more"). The caregiver does not have to take the sole responsibility for this task, credit may also be given if another adult in the home or an older child (13 years or older) performs the task.

Scoring Examples:

Example: Caregiver reports letting the kindergarten children show (child) how to count. Score "No".

Example: Caregiver reports that she lets the 10 and 12 year old children work on rote counting with (child) once they are in from school. Score "Yes".

Example: Caregiver reports that (child) is just now counting to three by rote and can recognize the first three numbers by their figures. She can usually hold up the correct number of fingers from 1-3. The caregiver plans to get (child) to count to 5 by counting with her and showing her the figures for 4 and 5 as she does. Score "Yes".

Example: Caregiver reports she turns on Sesame Street and they learn about numbers from the show. Score "No".

Lead-in Examples:

Observer: Kids this age seem to be real interested in being able to hold up the number of fingers for how old they are. Is (child) into this yet? How did she learn to do that. Do you do anything to help her?

Observer: A lot of children around this age get real interested in school and want to say the ABCs and count. Has (child) reached that point yet? What kind of things is she doing? How high can she count? Are you doing anything to help her?

Item #38 - Child is encouraged to learn to read a few words. The intent of this item is directed toward real reading, not just trying to teach the child to recognize her name and a few letters. This item is looking at true reading skills and not pre-reading skills (actually reading a few words as opposed to recognizing a few letters). Thus, credit for this item will most often be given to caregivers' work with children [illegible] the older end of the Inventory's age limit. Caregivers should take advantage of daily occurrences (such as grocery shopping, story reading, etc.) to call the child's attention to the association between the printed letters and sounds. Activities which would receive credit include: reading alphabet books (provided the caregiver reads the words the letters start with); giving the child paper and pencil and letting her copy letters and words; responding to the child's "what's that word", pointing out words on packages, signs, etc. Credit for this item calls for direct caregiver activity. Just letting the child play a computer game, work with flash cards or read on her own does not meet the intent of the item. These things are good activities, but must be incorporated with direct teaching activities on the caregiver's part to help the child understand the associations between what she sees and hears and says. The caregiver does not have to take the sole responsibility for this task, credit may also be given if another adult in the home or an older child (13 years or older) performs the task. This activity should be worked on at least once every 2 weeks for credit to be given.

Scoring Examples:

Example: Caregiver reports that she has started teaching the 3 year olds A, B, C, and D - just by looking at the letters and saying them. Score "No".

Example: Caregiver reports that she is teaching the 3 year olds to say their ABCs, but has not started showing them the letters yet, let alone started any reading activities. Score "No".

Example: Caregiver reports she has one 3 year old who was reading a few words when he came to her care four months ago. She thought, at first, that he had just memorized the book, but when she got a new book and sat down to read to him, he started saying a few words. At that point she started showing him new words and explaining what they stood for and how to say them. She even made some "flash card" games to match some of the new words they were working on to the objects. Score "Yes".

Example: Caregiver reports that (child) has shown no interest in reading and besides she thinks 3 year olds should play - they can learn to read when they go to school - that's one of the reasons they go to school. Score "No".

Lead-in Examples:

Observer: I noticed the children playing school over there a while ago. Does (child) like to do that? Does she try to read any words yet?

Observer: I see (child) reading a book. She is talking, but I am curious - is she really reading, just pretending or has she memorized the book?

Item #39 - Some delay of food gratification is expected. The intent of this item is to determine whether the caregiver requires the child to control his/her desire to eat, to wait until the time designated for eating comes. The hope is that the child will learn to delay gratification, a sign of maturity. In scoring this item, the observer should look at such things as: does the child snack at any time she wants; does the caregiver refuse to tolerate whining during the last 30 minutes of meal preparation; etc. The observer may wish to discuss this when talking about meal times. Credit would be given if: child is not allowed to snack whenever she chooses; child is not permitted a snack within 30 minutes of a meal; child is not permitted to nibble all day; etc. The item supposes that the caregiver has reasonable snack and mealtime schedules and is providing enough food to sustain the child from one eating period to another. The observer should ask the caregiver what rules/standards she uses and whether or not the children are really hungry, hungrier than usual (due to unusual physical activity) or if they are just bored. A caregiver who moves a snack or meal time up would not be scored "no" provided she has done so for a good reason, such as the children having an unusual amount of strenuous physical activity the past few days. Observers should also probe to determine if the caregiver explains to the child **why** s/he must wait. Credit may be given for any type of (reasonable) delay imposed.

Scoring Examples:

Example: Caregiver reports that lunch is served whenever she has taken care of all the babies. It usually is within an hour or two of 11:30. It all just depends on how long it takes to feed and change the babies. Score "No". An hour either before or after the designated time is too long for a child to delay a meal. Fifteen to 20 minutes either way would receive credit.

Example: Caregiver reports that she has a cabinet with crackers and cookies that is within the child's reach. The child is allowed to go get some whenever she wants. Score "No".

Example: Caregiver reports that she may move snack time by 5-15 minutes either way, depending on how involved they all are in an activity. She does say that if the children are begging for lunch 20-30 minutes before the time to eat, she explains to them that they must wait just a little longer until it is ready. Score "Yes".

Example: Caregiver reports that snacks are around the same time every morning and afternoon. She reports that she has pretty well figured out when the child needs to eat something to hold her over until meal time. She also reports that when (child) asks for something to eat shortly before a meal, she usually asks her to wait (telling her it won't be much longer before it is ready), but she has on occasion given her one cracker to nibble until lunch is ready, especially if she has been unusually active that day. Score "Yes".

Lead-in Examples:

Observer: We were talking about the eating arrangements earlier and I just wondered if (child) ever wants to eat before lunch is ready? How do you handle that - especially with this many children?

Observer: (Child) is really doing a lot of running around.

I bet she gets hungry today. Sometimes 3 year olds can really eat and at just about any time of the day. Does (child) ever want to eat before lunch is ready or between snack time and lunch?

Item #40 - TV is used judiciously. The main intent of this item is to determine if any attempt at regulating use of the TV is made. If the home or the caregiving areas have no TV, an automatic score of "no" is given. If the TV is turned on in the morning and not turned off until bedtime (with no regard to the program) an automatic score of "no" is given. If the TV is on most of the child's waking hours, an automatic score of "no" is given. Almost any attempt at regulating or scheduling will receive credit. Regulating which would receive credit would include: allowing children to watch only a certain type of programs; allowing children to watch only a certain number of programs; allowing children to watch only for a certain number of hours or minutes a day; TV turned off at meal times, nap times, when the children are having circle time or lesson time; etc.

Scoring Examples:

Example: Caregiver reports that the child is allowed to watch only Sesame Street and Barney during the day. Score "Yes".

Example: Caregiver reports that there is no TV in the rooms used for child care. Score "No".

Example: Caregiver reports that there is no TV in the rooms used for child care, but that she does take them upstairs each afternoon so they can watch Barney. Score "Yes".

Example: Caregiver reports that she limits the amount of time (child) can watch TV to two hours in the morning and two hours in the afternoon. Score "Yes".

Example: Caregiver reports leaving the TV on all day because it is the best babysitter around. Score "No".

Lead-in Examples:

Observer: I know that TV can be a lot of company. Do you usually leave it on all day or just turn it on for special programs?

Observer: Often watching TV can really keep the kids occupied. Does (child) like to watch TV? How often does she watch?

Item #41 - Caregiver introduces observer to child. In introducing the observer to the child, the caregiver is indicating that the observer has come to visit both of them. In order to receive credit, the caregiver must remind the child of the observer's name, even if the child already knows the observer. The key to this item is that the caregiver must tell the child the observer's name.

Scoring Examples:

Example: (Child), this is Miss Frances. She has come to watch you play today. Score "Yes".

Example: (Child), you remember Miss Brenda. She was here a few months ago to see you. Score "Yes".

Example: (Caregiver to observer) That's (child) over there in the blue shirt. Score "No".

Example: (Child) just go on and play. This lady has come to talk to me   Score "No".

Lead-in Examples:

This item is scored from observation alone.

Item #42 - Child can express negative feelings without harsh reprisal. The intent of this item is to determine whether the caregiver or another adult or older child (13 years or older) in the home uses "harsh" punishment when the child expresses negative feelings. The caregiver may set limits and use punishment which is not considered harsh and still receive credit. The observer must first determine if the child does (or has ever done) these things. Then she must determine what the caregiver does when it happens. Finally, a determination must be made as to whether or not the reprisal is "harsh". Some of the negative feelings expressed by the child would include: I don't like you; I hate you; I don't want to; No, I won't; etc. Harsh reprisals from the caregiver would include such things as: spanking the child (or using any type of physical punishment which hurts the child); yelling at the child; putting the child in time-out for an unreasonable length of time; withholding privileges; giving an overbearing lecture; yelling and threatening the child to keep him in time-out; threatening the child in a way that is cruel or frightening; etc. Negative expressions from the child (a big scene as in a temper tantrum or a little scene as in an "I don't like you") which invariably result in a "big scene" would be scored "no".

Scoring Examples:

Example: Caregiver reports "just picking him up and beating the tar out of him". Score "No".

Example: Caregiver reports sending the child to the time-out chair for 5 minutes. Score "Yes".

Example: Caregiver reports sending her to her room until she gets over it. It usually takes 1-1 1/2 hours. Score "No".

Example: Caregiver reports that what she does depends on what the child does. For things like "I don't like you" she just talks to the child. For temper tantrums, she sends the child to the time-out chair for 5-15 minutes. Score "Yes".

Lead-in Examples:

Observer: I have heard a lot of children who, by this age, have started expressing negative feelings such as "I hate you" or "No, I won't do that". Does (child) do anything like that? What kinds of things has she expressed? How do you deal with each of those expressions?

Observer: Sometimes kids have bad days just like the rest of us. They have what I call "the don't wants". They don't want to do this or they don't like that. Does (child) ever say negative things like that or have temper tantrums?

Item #43 - Child can hit caregiver without harsh reprisal. Once again, in this item the key is "harsh reprisal". A harsh reprisal would be physical punishment that hurts the child or any cruel or extreme disciplinary procedure. If the child has never hit the caregiver, score "yes". It is important to note that the caregiver is allowed to set limits and can punish the child for hitting her and still receive credit for this item **as long as the reprisal is not harsh.** Observers should first determine whether or not the child has hit the caregiver. Then probe to determine what the caregiver does when it happens.

Scoring Examples:

Example: Caregiver reports that (child) has never hit her. She has hit some of the other children, but never her. Score "Yes".

Example: Caregiver reports that she will not allow (child) or any of the other children to hit her. She hits them back to show them how it feels. Score "No".

Example: Caregiver reports that she tells the child how sorry she is that he hit her - that she really likes him and would not hit him. Then she asks why he hit her - if it is because she would not let him do something, she explains why. She reports that only once did she have to put him in time-out for about 5 minutes. Score "Yes".

Example: Caregiver reports she will not have a child hitting her. She just sends the child to her room and makes her stay there the rest of the day. Score "No".

Lead-in Examples:

Observer: There is something I have been interested in. I have seen children around this age hit their caregiver. Has (child) ever hit you? How do you deal with something like that?

Observer: I know that around this age children can really express their negative feelings and sometimes they even express them by hitting. Has (child) ever done anything like that to you? I am interested in what you do and how well it works.

Item #44 - Child is permitted some choice in TV viewing. The intent of this item is that the caregiver gives the child some choice in what to watch on TV. All of the child's wishes do not have to be catered to, but the caregiver and others in the house should not dominate the use of the TV. The caregiver may offer the child a choice of two suitable programs and receive credit, or she may just ask "do you want to watch TV" and "what do you want to watch" and receive credit. She may also allow each child in her care to have one day a week to choose what to watch and receive credit. If there is no TV or no TV watching allowed, score "no". If the child does not watch TV because s/he does not like to, score "yes".

Scoring Examples:

Example: Caregiver reports that (child) just never sits still long enough to watch TV. He would rather be doing something else. Score "Yes".

Example: Caregiver reports that she tells the children they can watch Barney in the mornings, but then the TV is hers for the rest of the day. Score "No".

Example: Caregiver reports that there are so many children she has had to rotate who gets to pick what to watch. Each child gets to choose for one day until they have all had a turn, then they start all over again. She reports that she does dictate how many hours a day they can watch. Score "Yes".

Example: Caregiver reports that they usually only watch Sesame Street and Barney except on days when the weather is too bad to go outside. Then she says she insists on watching the news at noon and her story (soap opera), but outside of that she lets (child) choose what to watch. Score "Yes".

Example: Caregiver reports they have no TV in the caregiving rooms and she only takes the children upstairs once every 2-3 months to watch a video. Score "No".

Lead-in Examples:

Observer: I see you have a TV in the playroom. Do you use it much? How do you manage when (child) asks to watch a certain show?

Observer: I know that TV can be a good entertainer for children. Do they watch any during the day? Does (child) ever ask to watch anything special? With this many children, how do you manage to let each of them see what they want?

Item #45 - Caregiver has an emergency medical and/or accident plan. This item is the same as that in the Infant/Toddler version of the H.O.M.E. Observers will receive some of this information while they are discussing the Profile. Again, only the definitions listed here should be used to determine scoring on this instrument. As in the Infant/Toddler version, in order to receive credit, **a caregiver must**

have emergency phone numbers listed (hospital, ambulance, doctors', parents' and parent back-ups' numbers). This listing may be on the wall by the phone, in a notebook kept by the phone or the numbers may be programmed into a phone. Secondly the caregiver must know that, in a serious emergency, **she would call 911**. In areas where there is no 911, the caregiver must know (and have listed) the numbers of which emergency agency she would call for help - police or fire, etc. Third, the caregiver must have **made plans for some other person** to either accompany the child in an ambulance or stay in the home with the other children while the caregiver accompanies the child. If the study child is the only child in care, this third requirement is not necessary to receive credit on this item.

Scoring Examples:

Example: Caregiver has phone numbers posted next to each phone in the house. She knows which situations would require calling 911. She says that she never really thought about it, but she is sure her neighbor across the street would come over if she had to accompany a child in the ambulance. Score "No".

Example: Caregiver (father) has emergency numbers programmed into the phones and has clear directions from his wife (a nurse) as to when to call 911 and when to call the doctor's office. This is their only child. Score "Yes".

Example: Caregiver reports she knows all the important numbers by heart. Her husband would be there to stay with the other children if she had to take (child) in an ambulance. Score "No".

Example: Caregiver has numbers posted by the phone, she has described which injuries would result in a 911 call and the doctor's office and she has made arrangements with the lady next door to come stay in the event of an emergency. Score "Yes".

Lead-in Examples:

Observer: What would you do if you had a serious emergency?

Observer: We all hope it will never happen, but what steps have you taken to deal with different types of emergencies and injuries - little injuries as well as serious ones?

Item #46 - At least 1 musical instrument is available to the child. For this item any type of musical instrument (real or toy) will receive credit as long as the child can actually use it to make music (i.e. a cheap plastic miniature toy horn would not count).. They would include: piano, drum, xylophone, guitar, horn, radio, etc. The instrument does not have to belong to the child personally, it may be shared. However, the child must be permitted to use it whenever s/he chooses in order to credit this item.

Scoring Examples:

Example: Caregiver has drums, horns, cymbals and all are available to be used by (child) as well as the other children when they want, not just during music circle. Score "Yes".

Example: Caregiver has horns, drums and bells that are kept up and only used for music circle. She does have a toy piano which is kept out and can be used by (child) at any time during the day. Score "Yes".

Example: Caregiver reports having toy instruments, but none are seen out. Upon probing, the observer discovers that the toys are kept on the top shelf of a closet and brought down only when the caregiver "feels like it". Score "No".

Example: Caregiver reports having no toy or real instruments. Score "No".

Lead-in Examples:

Observer: Children this age seem to really enjoy music. Do you have any kind of musical instruments, either real or toy? How often does (child) use them?

Observer: I see a toy piano over there, does (child) ever play it?

Item #47 - Child is taken on field trip by caregiver at least every other week. The intent of this item is that the child is exposed to a variety of experiences. The child needs to do more than play outdoors in the yard or take a weekly walk around the block. Observers should be looking for educational types of trips. Excursions which would receive credit include: a trip to the mall, a trip to the barber and/or beauty shop, a picnic in the park, a trip to the zoo, a trip to a farm, a trip to a movie, a trip to the ice-cream shop, etc. Simply going to another caregiver's home to play with the other children is not sufficient to receive credit if that is the only type of excursion taken. The caregiver does not have to take the sole responsibility for this task, credit may also be given if another adult in the home or an older child (13 years or older) performs the task.

Scoring Examples:

Example: Caregiver reports going somewhere every week. They usually go to the zoo once a month, the library, the mall, the pet store, etc. Score "Yes".

Example: Caregiver reports they only walk down the street to visit a lady who keeps children and has a big back yard full of swings and other toys. Score "No".

Example: Caregiver reports going somewhere every other week such as the mall, the library, the zoo, etc. Score "Yes".

Example: Caregiver reports that the neighborhood is so unsafe that she does not take the children out for any types of outings. Score "No".

Lead-in Examples:

Observer: Children this age often like to go places. Do you ever take the children any place besides out in the yard? Where are some of the places you go? How often do you get to do that?

Observer: I see (child) caring her purse around like she is going somewhere. Does she ever want you to take her places? Do you ever have the time to do that? Where are some of the places you go? How often do you get a chance to do that?

Item #48 - Child is taken outside for play every day the child is in care (except in bad weather). Observers may credit this item as long as the play is outdoors - outdoors may be a yard, a courtyard, a play ground, a field, a park, etc. The following examples will deal with what are considered exceptions in bad weather. A good rule of thumb is to give credit if the caregiver usually takes the child out everyday, except in unusual circumstances. There should be no more than 3-4 of these unusual circumstances per year and they should be of short duration (no more than a week or so). We are talking about unusual weather situations. We believe children can go out in cold weather, in snow and in rain, just not in exceptionally bad weather. Observers should determine how often the child goes outside to play and (if the caregiver does not take her out when the weather is bad), what kind of weather is too bad for them to go out. The caregiver does not have to take the sole responsibility for this task, credit may also be given if another adult in the home or an older child (13 years or older) performs the task.

Scoring Examples:

Example: The weather has been sunny and pleasant. The caregiver reports that (child) has the flu and she has not let him go out for 5 days. Ordinarily they go outdoors two times a day. Score "Yes".

Example: The weather is 20 degrees below zero, this occurs approximately 4-5 months a year and the caregiver does not take the child out during this time. Score "No".

Example: The weather is 32 degrees or above. It has been raining for 7 days - a light rain - and the caregiver does not take the child out. Score "No". If the caregiver does take the child out score "yes".

Example: The weather is above freezing and it has been raining for 5 days. The rain has been so heavy that the yards have water standing in them and flood watches have been posted. During the heaviest periods of rain, water is running over the street curbs and into yards. The caregiver has not taken the child out during this time because the rain is so hard it soaks through umbrellas. Ordinarily the caregiver takes the child out 2 times in the morning and 1 time in the afternoon. Score "Yes".

Example: You are in an area where the sun rarely shines and it rains most days for a 5-6 month period. The caregiver takes the child out only when it is sunny. Score "No".

Example: You are in an area where the sun rarely shines and it rains most days for a 5-6 month period. The caregiver takes the child out for a 10-15 minute play period every day. Score "Yes".

Example: You are in a climate that is warm. In July there is a heat wave. Warnings and alerts have been posted to keep young children and elderly people inside during certain portions of the day (usually 10-4). This situation usually occurs once every 1-2 years, lasting for about 7-9 days. The caregiver keeps the child in during this week, but ordinarily takes him out every day. Score "Yes". If there are never heat alerts, but the caregiver does not take the children out during the 10:00-4:00 period from June 1-September 7, score "no".

Example: You are in Canada. The snow is usually no less than 36 inches deep for 6 straight months. The caregiver takes the child out everyday. Score "Yes". If the caregiver does not take the child out, score "no".

Example: You are in Tennessee. There has been no snow that has stuck to the ground for 5 years. There is a near-blizzard and it has been snowing for 3 days. The child normally goes out each day, but since it has been snowing, the caregiver has not let her go out. Score "Yes". If the caregiver lets her go out even in the snow, score "yes".

Lead-in Examples:

Observer: I noticed (child) was playing outside yesterday. How often does she play outside? When you say "except in bad weather" what kinds of weather would keep you and (child) indoors?

Observer: This weather has really been nasty this week. Has (child) been able to get out at all? How often does she usually get out?

Item #49 - Child has been involved in art/craft activity during the past week. Credit for this item may be interpreted fairly liberally, but the activity must be structured to the degree that there is a goal of learning or creativity present. Thus, although the activity may be executed solely by the child, the caregiver must have some input into the planning of the activity. The activity need not be a formal "circle" or "classroom" project. It may be done on an individual basis, with several children working on different projects at the same time. Merely coloring in a coloring book or on a piece of paper, scribbling on paper, tearing paper, or stacking/rearranging items is not enough. The child should be able to manipulate the materials to some degree by him/herself. The caregiver does not have to take the sole responsibility for this task, credit may also be given if another adult in the home or an older child (13 years or older) performs the task.

Scoring Examples:

Example: Caregiver reports she has a planned art project each week. She plans the projects to help develop skills such as cutting, pasting, staying inside the lines, etc. Score "Yes".

Example: Caregiver reports she has an art circle two times a week. She does not have anything special the child must do but always asks what would she like to do: paste, paint, color, etc. Once a choice is made, the caregiver then proceeds to discuss with the child what she might make using those materials. She also stays in the area to make suggestions on procedures if warranted. Score "Yes".

Example: Caregiver reports that all art supplies are left out and (child) can use them at any time. Score "No".

Example: Caregiver reports she has an arts/crafts project at least once a week. She always has each child doing the same thing such as coloring mimeographed birds, pasting feathers on turkeys, etc. She does all of the preparation work, such as cutting out the feathers, and then lets the children do the work, with her using a hand-over-hand approach in spreading paste, laying the feather on the bird, etc. She reports that it takes a long time to do even a simple project, but she thinks that method has really helped the children learn how to do some things. Score "No".

Lead-in Examples:

Observer: I see a table with lots of crayons and other art supplies over there. Does (child) do much art or craft work? What are some of the things she does? How do you set up an art activity?

Observer: Children this age always seem to like to draw and color. What about (child)? How do you manage those kinds of projects with this many children?

Item #50 - Caregiver encourages child to put away toys without help. In order to receive credit for this item, the child does not actually have to comply each time s/he is asked. Rather credit is given for the caregiver actually trying to get the child to do so without her help, instead of the caregiver doing it herself because it is easier. Credit should be given as long as the caregiver tries. The caregiver does not have to take the sole responsibility for this task, credit may also be given if another adult in the home or an older child (13 years or older) performs the task. The observer may probe for when toys are put away, such as after a play session, before lunch, before going outside, before going home, etc.

Scoring Examples:

Example: Caregiver reports it is just easier to do it herself. Score "No".

Example: Caregiver reports she asks (child) to put them away and he usually does, but the toys don't always get put on the right shelf. Score "Yes".

Example: Caregiver reports that she has all of the 4 and 5 year olds put the toys away, even though (child) sometimes tries to help them. She has never asked (child) to put the toys away as that is the older kids job. Score "No".

Example: Caregiver reports that (child) has been picking up the toys he uses as well as those used by other children. She started teaching him to pick the toys up as soon as he came to her for care. He even knows where they belong and will bring her those that go on shelves that are too high for him to reach. Score "Yes".

Lead-in Examples:

Observer: It seems like kids this age are always wanting to help you around the house. Does (child) like to help you? What kind of things does she do? Do you ever try to get her to pick up her toys?

Observer: I noticed yesterday that you asked two children to pick up the toys before lunch. Do you do that every day? Does (child) ever get asked to help?

Item #51 - Caregiver uses complex sentence structure and vocabulary. Credit should be given if the caregiver makes an attempt to carry on a regular conversation instead of just answering all questions with "yes", "no", or "I don't know", or other brief responses. The caregiver must give some elaboration beyond simple one word or one phrase answers. The caregiver must use some sentences that contain 2 or more clauses and some words that are unusual or poly-syllablic. Constant use of short sentences results in a "no" score. The observer should not base the score for this item on the first few minutes of the visit, especially if it is the first time she is visiting this caregiver, since she may be nervous.

Scoring Examples:

Example: Caregiver's reply to "Does (child) ever put her toys away?" is "yes." Score "No".

Example: Caregiver's reply to "Does (child) ever put her toys away?" is, "Yes, I always ask him to pick them up by himself to show me what a big boy he is and how much help he is to me." Score "Yes".

Example: Caregiver's reply to "Does (child) ever put her toys away?" is, "Yes, I try to." Score "No". Because this reply does not answer the question.

Example: Caregiver's reply to "Does (child) ever put her toys away?" is, "I ask him, but he never has." Score "Yes".

Lead-in Examples:

This item is scored by observation alone.

Item #52 - Child's art work is displayed in some visible place in the caregiving home. The art work can be anything the child has drawn or constructed. If the work cannot be observed in the room(s) where the observer conducts the visit, the observer should probe to determine if the art is displayed somewhere. In order to receive credit, the caregiver must have some work by the child displayed in some area visible to the child and others in the home. The only time this item would receive credit when no art work was displayed is when the caregiver is in the process of changing a display **when** the observer arrives.

Scoring Examples:

Example: Caregiver says they put up work each week and leave it up for about 2 days. Score "No".

Example: Observer notices the child's drawings on the refrigerator door while there for the visit. Score "yes".

Example Caregiver has placed all the child's work in a scrapbook. Score "No".

Example: Caregiver has a rope strung in one corner of the classroom, like a clothes line. She has it divided into sections so that each child can hang their art work up and change it as they wish. Score "Yes".

Lead-in Examples: This item is usually scored from observation, but there are circumstances where it may be necessary to ask.

Observer: You mentioned earlier that (child) likes to color. What do you do with her pictures when she has finished?

Observer: I see some art masterpieces being stuffed into tote bags. Do you send all of (child's) art work home?

Item #53 - Child eats at least one meal per day with caregiver and/or other children. This item is similar to the item dealing with mealtime in the Infant/Toddler version of the H.O.M.E. used during the 6, 15, and 24 month assessment periods. Credit would be given if the study child eats with other children. Credit would also be given in the situation where the study child is the only child present so long as the caregiver sits with the child - the caregiver does not have to actually eat, but must sit and provide a social atmosphere for the meal. This item does not pertain to the child's snack time.

Scoring Examples:

Example: Caregiver reports that (child) eats with the other children at the small table. Score "Yes".

Example: Caregiver reports that (child) leaves before lunch. Score "No".

Example: Caregiver reports that she is cleaning up the kitchen while (child) is eating. There are no other children in care. Score "No".

Example: Caregiver reports that she feeds the baby his bottle while sitting at the table with (child), but she does not eat herself. Score "Yes".

Lead-in Examples:

Observer: How do you manage lunch with infants and toddlers and 3 and 4 year olds all needing your attention at the same time?

Observer: I see you have several highchairs and two small tables with chairs. Where does (child) eat lunch?

Item #54 - Caregiver arranges for child to have vigorous physical activity 3 or more times a week. Many different physical activities could receive credit for this item. The activities may be indoor or outdoor activities. They need to be structured by the caregiver to the degree that they involve more than the child just running and playing outdoors. The caregiver does not have to take the sole responsibility for this task, credit may also be given if another adult in the home or an older child (13 years or older) performs the task. The activities need to be more of an aerobic nature. They need to be rapid enough in body movement that the heart rate is raised. Walking and playing catch are not vigorous enough. Activities which would receive credit are; running games, jumping games, skipping rope, exercises, etc.

Scoring Examples:

Example: Caregiver reports that she has games they play once a day like the bunny hop, hopscotch, and they are trying to learn to jump rope. Score "Yes".

Example: Caregiver reports they run and play so hard on their own she has not really worried about it. Score "No".

Example: Caregiver reports she takes the children to the school in the next block and they run the track 3 times a week. She also reports that she has been timing them and giving ribbons like the Olympics. The kids love it. Score "Yes".

Example: Caregiver reports she has a college girl come once a week to teach tap dancing to the children. The children do practice on their own during the day, but she (the caregiver) does not ask them to. Score "No".

Lead-in Examples:

Observer: Everyone has become so very health and heart conscious lately, I was wondering if you have (child) do any type of activity that would raise his heart rate?

Observer: (Child) seems to have so much energy I just wish I could harness some of that for me. I can just imagine what an exercise class might be like with her leading it. Does she do any kinds of physical activities, more like aerobic exercise, in addition to just all of the chasing the boys?

Item #55 - Caregiver does not scold or derogate or yell at child more than once during the visit. The intent of this item is to determine whether the caregiver speaks to the child in a cruel, demeaning, or abusive manner. All remarks must be directed at the child, they may not be told to the observer. (Caregiver tells child "you are a bad boy" would be counted, but the caregiver telling the observer "he is a bad boy" would not.) There must be two such instances in order to score "no". During the visit (second day when H.O.M.E. is adminstered) if any adult or older child (13 years or older) in the caregiving home scolds, yells at or derogates the child more than once, the item qould be scord "No". Any other adult or older child (13 years or older) in the home scolds, yells at or derogates the child more than once the item would be scored "No'.

Scoring Examples:

Example: Caregiver tells child, "You are just awful". Count as one of the two needed to score "no".

Example: Caregiver tells the observer that, "(Child) is so mean". This would not count as one of the two needed to score "no".

Example: Caregiver yells, at the top of her lungs, "(Child) get out of my drawer." Count as one of the two needed to score "no".

Example: Caregiver tells the observer that she is, "going to skin him alive if he doesn't stop that." This would not count as one of the two needed to score "no".

Lead-in Examples:

This item is scored by observation alone.

Item #56 - Caregiver does not use physical restraint during visit. Any act which restrains the child physically would result in a score of "no". Any other adult or older child (13 years or older) in the home restraining the child would result in a "no" score. Acts which would be considered physical restraint include: forcing a child to sit in a chair; jerking him back from handling objects; grabbing the child; shaking the child; holding the child down. etc. Do not confuse this with regular time-out procedures (ie. Caregiver tells child to go sit in time-out chair - this would not be use of physical restraint. But a caregiver who pushes the child bodily into the time-out chair would be scored as using physical restraint.)

Scoring Examples:

Example: Caregiver forces child stand on a square until he says I'm sorry. Score "No".

Example: Caregiver jerks child's hand away from the cookie jar. Score "No".

Example: Caregiver jerks child, bodily, away from the observer. Score "No".

Example: Caregiver shakes child when he stops listening to her. Score "No".

Lead-in Examples:

This item is scored on observation alone.

Item #57 - Caregiver neither slaps nor spanks child during visit. This item is fairly self-explanatory. All slaps and spanks must be done in anger to score "no". Any adult or older child (13 years or older) in the home slapping or spanking the child would result in a "no" score. An affectionate pat on the bottom as the child goes out to play would not be scored "no". The observer must watch those situations where the roughhousing between a caregiver and a child includes slapping or spanking as part of the tussle. Watch the child's expression. This expression is usually a good indicator of when hitting stops being play and becomes punishment or abuse.

Scoring Examples:

Example: Caregiver slaps the child as he reaches for a cookie. Score "No".

Example: Caregiver spanks the child for hitting another child. Score "No"

Example: Caregiver gives the child an affectionate spank on the bottom - the child grins the whole time. Score "Yes".

Example: Caregiver playfully spanks the child because it is his birthday. The child is laughing so hard his face is red. Score "Yes".

Lead-in Examples

This item is scored from observation alone.

Item #58 - No more than one instance of physical punishment has occurred during the past week. This item is similar to the item dealing with physical punishment in the Infant/Toddler version of the H.O.M.E. used for earlier assessment periods. The key to this item is that the instances of punishment must have occurred during the past week. Remember, it is not asking for how many times the child is generally punished in a week. Physical punishment can include; spanking, slapping, hitting, pinching, shaking, hand slapping, etc. Instances of physical punishment inflicted by anyone in the home (another adult or an older child, 13 years or older) would count in scoring this item.

Scoring Examples:

Example: Caregiver reports that she has not had to spank (child) in the past week, although she did have to slap his hands about four times. Score "No".

Example: Caregiver reports that the only thing she has had to do in the last week was spank him once. Score "Yes".

Example: Caregiver reports she has to spank (child) at least once a day. Score "No".

Example: Caregiver reports she uses no physical punishment, only time-out. Score "Yes".

Example: Caregiver reports that she usually only has to squeeze his wrist or arm until he grimaces to get him to do what she (cargiver) wants him to do. Score "No".

Lead-in Examples:

Observer: With this many children you must be forced to have some rules for the children to follow. What are some you have for (child)? What do you do when she does not follow them? Do you ever have to spank her or use any physical punishment to get her to mind?

Observer: We are interested in finding what types of discipline caregivers use and what works best for them. What do you do when (child) does not mind?

Key and Explanations

Items #1-11

Item #1 - Score "YES". The caregiver has two toys (shape sorter puzzle and nesting dolls) and she uses them to teach colors and sizes and shapes. If she had only the shape sorter puzzle and used that to teach colors and shapes, but had nothing to teach sizes, the score would have been "no".

Item #2 - If the puzzles are available to the child, the score would be "yes". However, this conversation did not continue long enough for the observer to ask (if she did not see) where the puzzles were kept. If the observer did not see the puzzles and the only information she has is that printed here, the score would be "no". Although there were 3 or more puzzles, she does not know if they are available to the child.

Item #3 - From the information listed in this conversation, observers would have to score "no". Although the child is allowed to operate the tape recorder and has a tape of songs, the observer did not probe to determine if there were more children's tapes available. The item calls for 5 or more children's records or tapes. Had the conversation continued and the observer probed to determine the number of tapes, it is possible that the score could have been different.

Item #4 - Score "YES". The crayons & paper and play dough are out and within the child's reach (available) at all times.

Item #5 - Score "YES". Crayons & paper and legos are available at all times and the scissors are brought out when he wants them. The restriction of the caregiver not bringing the scissors out when she is feeding a baby is acceptable and well within reason for scoring purposes of this item.

Item #6 - Score "YES". The caregiver has more than two toys or games available to the child and she reports she helps the child use them to learn numbers.

Item #7 - Score "YES". Two shelves of children's books are available to the child.

Item #8 - Score "YES". This is a clear "yes" on both counts. The caregiver has approximately 10 books in the caregiving area at all times and many more in the den that the children see daily.

Item #9 - Example #1 would be scored "no". However, I feel there should be more probing to determine if the caregiver ever uses their nap time for reading the front page of the paper.
Example #2 would be scored "yes". The child is usually not asleep when the caregiver begins reading the paper. She also reports the child is in a position to see her reading if he so desires.

Item #10 - Example #2 is the only conversation with enough discussion to score. Score "YES". The caregiver buys two magazines at the grocery store on a regular basis. They are the same two magazines.

Item #11 -Score "YES". The caregiver has been helping the child learn shapes for the last three months

IV. PROBLEM SOLVING FOR THE ENTIRE VISIT

Here are some of the problems we have anticipated with suggested actions.

- The child is absent. Try to find out why the child is not present. If the child is sick, call the parent to find out when the child will be back so that you can reschedule your observation within the allotted window.

- The child goes to the bathroom (older children) during observation period. Stop the tape. Once the child returns to the room, begin the observation again. Do not stop for a diaper change.

- The children go for a walk, to the store, etc. Continue observation.

- A crisis arises during your visit and the caregiver asks you to babysit. You are not a babysitter and cannot be responsible for looking after the children in her care during her absence. He/she should make whatever arrangement he/she would have if you were not there. (However, when a conflict between scientific and ethical principles arises, be ethical, be humane, use common sense and good judgment, call your PI or PC.)

- A child is in danger and the caregiver is busy elsewhere. Do not let an accident happen while you stand by. Alert the caregiver or intervene.

- The child lies down for nap or goes to sleep.
    - during the first observation cycle on Day 1. If you have at least 20 minutes of the 30 minutes of Behavioral observation,

do the Qualitatives based on that 20 minutes, then do the Profile observation. Ask the caregiver if the child is likely to awaken in the next hour or so. If this is likely, you may want to wait to do another observation cycle; if you do not want to wait, give the caregiver(s) the questionnaires, schedule a second visit and leave. You will have to do 3 observation cycles on Day 2. Under these circumstances, you will probably have to conduct any scheduled Peer Observations on a third visit.

♦ during the second observation cycle on Day 1. If you have at least 20 minutes of the 30 minutes of Behavioral observation, do the Qualitatives based on that 20 minutes, then do the Profile observation. Give the caregiver(s) the questionnaires, schedule a second visit and leave. You should do 3 observation cycles on Day 2. Mail all cycles, whether completed or not, to the DCC. Under these circumstances, you will probably have to conduct any scheduled Peer Observations on a third visit.

♦ during the third observation cycle on Day 1. This was your insurance cycle. If you have at least 20 minutes of the 30 minutes of Behavioral observation, do the Qualitatives based on that 20 minutes, then do the Profile observation. Give the caregiver(s) the questionnaires, schedule a second visit and leave. You will need to do 2 cycles on Day 2.

♦ during the first observation cycle on Day 2. If you have at least 20 minutes of the 30 minutes of Behavioral observation, do the Qualitatives based on that 20 minutes. If a peer observation is to be done this will be your 4th cycle. Proceed with the interviews and the Peer Observation Procedure. If, on the other hand, there is no peer observation to be done in this setting and this is your third cycle, ask the caregiver if the child is likely to awaken in the next half hour. If this is likely and you only did 2 observation cycles on Day 1, you may want to wait to do another observation cycle; otherwise, you will need to schedule a third visit (although try to avoid having to schedule a third visit). Do not do the interviews until you have (at least) 4 observation cycles complete.

♦ during the second observation cycle on Day 2. If you have at least 20 minutes of the 30 minutes of Behavioral observation, do the Qualitatives based on that 20 minutes. Then proceed with the interviews.

♦ The child becomes aware that you are observing her/him. Stop the audiotape and turn your attention to another part of the room. After 2 minutes resume your observation. Do this only once. After that avoid eye contact. Look away, at your papers, the wall, another child, or the caregiver (and code child's activity as "unoccupied/watching" if child continues looking at you.)

♦ The target child or another child persists in interacting with you. Attend to the child briefly by telling her/him that you have to work. You can begin writing or redirect your attention elsewhere. If you were sitting, try standing up to do the observation. If you were located in the midst of the children's activity, try moving to another position.

♦ The caregiver leaves or goes on break in middle of observation. Go on observing. When the observation is complete, if the caregiver is just on break, you can do the interview during or after the break. If the caregiver has left the premises you can do the interview over the phone. (It will be important to know the schedule of the primary caregiver, especially when he/she usually leaves, before you schedule your visit, so as to avoid these situations.)

♦ The caregiver refuses to participate in the study. First, try to ascertain why the caregiver has concerns. If possible, try to answer the questions that he/she has. Explain the importance of her/his contribution. However, if the caregiver still refuses there is not much else you can do.

♦ The caregiver attempts to engage you in conversation during the observation. Let her/him know that you do want to talk, but that you have to time the observation. Tell her that you will have an opportunity to talk at the end of the observation (in about x minutes, or on your next visit).

♦ The mother shows up while you are observing. Stop the observation and wait till she has gone to start it again. Perhaps you could do the Profile observation in the meantime.

♦ The caregiver asks you what you are observing. Only general information should be given to caregivers and should be specific to questions actually asked. Emphasis should be on our wish to capture the child's experience in the setting and not on any desire to evaluate the quality or adequacy of the center, home, or caregiver. Emphasis should be on the "exploratory" (vs. evaluative) nature of the data collection: We don't know how children's experiences contribute to their development unless and until we collect information about those experiences.

♦ The parent asks for information about the child care setting. Most times the person talking to the parents will not have any information about the child care setting because a different observer will be making these visits. Parents who ask, however, should be encouraged to observe in their own daycare sites, to talk to their caregivers about their concerns, etc. They should also be told that decisions about day care arrangements are personal ones, and that what makes one parent comfortable will not necessarily make another parent happy; hence our advice is not as important as the parents' personal observations and values. You could also say that the caregiver has signed a consent form assuring her that the information you collect will be confidential.

♦The care you are observing is suboptimal. It is our responsibility to report any clear cases of abuse or neglect (see Manual for 1-month visit for details). If care is not truly abusive or neglectful, however, although it may be chaotic, inattentive, noisy, or bleak, it is not appropriate for the observer to intervene or to report the inadequacy of the care to the parent. To do so would jeopardize our opportunity to gather data on less than ideal day care. Potentially life-threatening or injurious, but not abusive, practices (e.g., open fire, open stairway, open window, small toy parts available to children, etc.) should be brought to the attention of the caregiver(s)/director and to your PC and PI. If not remedied it may be appropriate to bring it to the attention of the parents.

♦ The caregiver asks for information about child care, the child, child abuse, etc. Tell the caregiver you need to check with the PI/PC, and then together you can come up with some reasonable and specific answer. It has been suggested that we put together a packet of resources for caregivers, but I think we should just have such a packet on the PC's desk and draw from it selectively and only as requested/required.

V. OVERVIEW FOR SEASONED OBSERVERS

The same procedures will be followed at 36 months as at 6, 15 and 24 months for recruitment, obtaining consent, order of procedures, number of visits, number of observation cycles, ORCE coding, administration of observations, interviews and questionnaires, and training and reliability (except, of course, the details of time and place for the last). The one addition is the 15-minute peer observation on Day 2 and the responsibility of conducting the peer observation for all study children regardless of use of child care. Note, however, that every assessment instrument has changed, some in minor ways and some in major ways.

Timing of visits. The first child care visit should occur after the home visit and within the period between the child's 36th- and 38th-month birthdays. The second visit should occur as close as possible to the 1st and definitely not on or after the child's 41-month birthday. No arrangement or classroom should be visited until the child has been enrolled for at least 2 weeks. If possible, child care assessments should be made within 1 month of the 36-month home visit.

Assessment Measures:

Child Care Provider Packet. All of the questionnaires are the same as those used at 24 months: "When Parent Leaves/Returns" (McCartney Pick Up/Drop Off), "Ideas about Raising Children" (Schaefer Modernity), "Taking Care of Young Children" (Marshall Caregiver Stress), "My Feelings", "Child Behavior Checklist (Achenbach), and Adaptive Social Behavior Inventory (Scott and Hogan).

Profile. The profile has been adapted for 36-month-old children.

Home. The preschool version of the HOME is used at 36 months.

Behavioral Scales. The Behaviorals procedure and scales are the same as at 24-months; however, there are clarificatons for someitems to make the definitions developmentally appropriate for 36 month olds.

INTERVIEWS. The interviews at 36 months are the same as those used at 24 months.

Director Interview for Child Care We Cannot Visit

Director Phone Interview

Director Background Information Questionnaire

Director Questionnaire. (Long and Short Form) If the director has completed the questionnaire before for target child or another child in the study, use the "Director Questionnaire for Centers we Have Visited." If the director has not completed the questionnaire before, it is the same.

Caregiver Interviews. If the caregiver has never been interviewed before use the long form. If the caregiver has been interviewed before, for the target child at 24 months or for another child in the study, use the short form.

Peer Observation Procedure. This procedure has been added to the 36 month child care visit.

VI. CHILD CARE ASSESSMENTS AT A GLANCE

In a center:

A. Recruit the director and do director telephone interview.
B. Send information confirmation letter, and Director Questionnaire and Director Background Information Questionnaire
C. Send information to parents of peers for peer observation.
D. Confirm visit the day before the scheduled visit.
E. Call the morning of the visit to ensure the child is present
F. Do first visit:
    1. See director, get/go over Director Questionnaire/consent forms
    2. 3 ORCE cycles
    3. Profile observation and interview items
    4. Child care provider packet
    5. Explain Peer Observation Procedure and enlist caregiver help if needed
    6. Post Visit Interview
G. Do second visit:
    1. 1 ORCE cycle
    2. Peer Observation Procedure
    3. Child Caregiver interview with caregiver 1
    4. Child Caregiver interview with caregiver 2
    5. Post Visit Interview and Rating of Caregiving Environment
    6. Pick up caregiver questionnaires
    7. Payment and receipt

In a daycare home or Child's home:

A. Recruit provider
B. Send information and confirmation letter
C. Follow procedures to get permission from peer's parent for peer observation.
D. Confirm visit the day before the scheduled visit
E. Call the morning of the visit to ensure the child is present.
F. Do first visit:
    1. Warm-up chat + consent form(s)
    2. 3 ORCE cycles
    3. Profile observation and interview items
    4. Explain Peer Observation Procedure if appropriate and enlist Caregivers help, if needed
    5. Post Visit Interview and Rating of the Caregiving Environment
    6. Leave caregiver questionnaires
G. Do second visit:
    1. 1 ORCE cycle
    2. Peer Observation Procedure
    3. HOME interview
    4. Child Caregiver interview
    5. Child Caregiver interview with caregiver 2, if necessary
    6. HOME completed
    7. Post Visit Interview and Rating of the Caregiving Environment
    8. Pick up caregiver questionnaires
    9. Payment and receipt

VII. APPENDICES

A. Recruitment Letter for Child-care providers

Dear

As you may already know, (child's name) is taking part in an exciting and important study -- the National Institute of Child Health and Development Study of Early Child Care. He/she has been in the study since he/she was born.

The study aims to learn how the different people, places and events in the lives of young children affect their development. Enclosed is a brief description of the study that tells you more about it.

Because child care provided by adults other than parents is such an important part of children's early experiences these days, we would like to see (child's name) in his/her child care setting. We would like to come and see (child's name) when he/she is with you. His/her parent(s) have given their permission.

We know you are busy, but we would try not to disrupt your routine and we would try to work around your schedule. You would not need to do anything special because we were there. We want to see what (child's name) is usually like when he/she is with you. One of our staff would just watch (child's name) doing whatever he/she typically does and ask you some questions about his/her activities and about your background and experiences. The only time we will ask for any special activities is a 15-minute observation of STUDY CHILD with another child. Some of these questions can be answered during the visit; others would be answered on a form that he/she would leave for you to fill out.

Your participation in the study will provide valuable information which will help all of us learn more about young children's development.

In appreciation of your help we will pay you $40.

We will be calling you to tell you more and to answer any questions that you may have about the study. If you want to call us in the meantime, the number is.....

B. Confirmation Letter to Home Care Provider

Dear

Thank you for agreeing to participate in the National Institute of Child Health and Development Study of Early Child Care. It is very important for us to be able to observe (TARGET CHILD) while in your care. Your willingness to let us visit will help us understand how both family care and child care can affect children's development.

As we discussed on the phone, we have scheduled the first of our two visits on ____________________________ from ______ to ________ (approximately). The second visit will be on ______________ from ____________ to _________ (approximately).

With this letter, we have enclosed a brief description of the study and our visits [FOR SITES THAT NEED TO SEND CONSENT FORM IN ADVANCE: and a copy of the consent form (we will bring an extra when we come)]. When we come for the visit, we will ask you to sign a consent form, assuring you of the confidentiality of our observations.

Once the visits are completed and you send in a questionnaire we will leave with you we will make you a gift of $40, in appreciation of your time, and, if you are interested, we will send you a report of the findings when the study is completed.

I will call you the day before the first visit to confirm the visit. Please call us if you have any questions before then (phone number).

Yours sincerely
Staff Member
Project Coordinator
Project Director

C. Confirmation Letter to Center Director

Dear

Thank you for agreeing to participate in the National Institute of Child Health and Development Study of Early Child Care. It is very important for us to be able to observe (TARGET CHILD) while in your care. Your willingness to let us visit will help us understand how both family care and child care can affect children's development.

As we discussed on the phone, we have scheduled the first of our two visits on ____________________________ from ______ to ________ (approximately). The second visit will be on ____________ from ___________ to _________ (approximately). Please talk to the caregivers who take care of (TARGET CHILD) before we come to visit. This is very important.

With this letter, we have enclosed (1) a brief description of the study and our visits (for you to post if you wish) and (2) a questionnaire that we would like you to fill out [FOR SITES THAT NEED TO SEND CONSENT FORM IN ADVANCE: and (3) a copy of the consent form (we will bring an extra when we come)]. When we come for the visit, before we begin our observation, we will ask you and the staff who participate to sign a consent form, assuring you of the confidentiality of our observations.

Once the visits are completed and we will make a gift of $40 to the center, in appreciation of your time, and, if you are interested, we will send you a report of the findings when the study is completed.

I will call you the day before the visit to ask you some questions about your program. This will save time during the actual visit. Please call us if you have any questions before then (phone number).

Yours sincerely
Staff Member
Project Coordinator
Project Director

D. Description of Study

Children born today will be growing up in a world different from that of their parents. How will growing up in the 1990's affect children's development? To answer this most important question for American's future, the National Institute of Child Health and Human Development has funded the Study of Early Child Care.

The Study of Early Child Care is being conducted at ten different sites in the United States. The main aim of the study is to learn about the variety of people, places, and events that children experience in their early years and the many pathways that lead to healthy development. Aspects of development that are being studied include social relationships, language, intellectual abilities, and health.

Families become involved in the study on a voluntary basis soon after the child's birth. Several times during the three years that the families are involved in the study, the children and their parents are observed and interviewed. Parents are asked to describe their views about child rearing, their feelings about working and parenting, and their perceptions of the child's personality and behavior. Because child care outside the family is also an extremely important setting in which children grow and change, caregivers are asked to participate as well.

Each child in the study is visited in his or her care setting over two or three days, when he or she is 6, 15, 24, and 36 months of age.

During the visits, a staff member observes the child for about 3 hours. He/she tries not to interfere with the usual routine in the child's room. For one 15-minute period, he/she videotapes the child and another child playing with some special play materials that we will bring. Then, he/she talks to the caregiver(s) briefly about the child's activities and about the caregiver's education and experience. This takes less than an hour 20 minutes of the caregiver's time, and the staff member works around her schedule. At the end of the visit, he/she leaves some questionnaires for the child's caregiver(s) to fill out. These questionnaires contain questions about the child and about the caregiver's views on child care.

Because we want to see what usually happens when children are in child care, we try to make our visits interfere with the caregiver's routine as little as possible.

The results of this study will not only guide policy makers, but will also be of more immediate use to parents and child-care providers as they engage in the rewarding, but challenging, responsibility of rearing young children.

E. Consent Form

Children born today will be growing up in a world different from that of their parents. How will growing up in the 1990's affect children's development? To answer this most important question for America's future, the National Institute of Child Health and Human Development has funded the Study of Early Child Care.

The University of California - Irvine, is one of 10 sites across the country conducting this study. The purpose of the study is to learn about the variety of people, places, and events that children experience in their early years and how these relate to their development. Children are observed periodically from the time they are one month old until they are 3 years old. Their parents are interviewed about the children's experiences at home and in other settings.

You are caring for one of the children, (name), who is participating in the study. We wish to observe the child while he or she is with you. The child's parent(s) have consented to this visit.

We will try not to interfere too much with your routine. A staff member will come to watch the child's activities for about three hours, on each of two different days. You do not need to do anything differently for the visits. We want to see what usually happens when the child is with you. We want to see the CHILD's typical day -- what he does, who he plays with, how he acts with you. The only time we will ask for any special activities is a 15-minute observation of STUDY CHILD with another child. We will also talk to you about the child's activities and your experiences in looking after children.

He/she will ask you some questions about your education and goals. Some of these interviews may be tape recorded. The staff member will also have you fill out forms asking about the infant and about your experiences and your views on childrearing.

Our visit with you will help everyone understand how both care at home and in child care can lead to healthy development.

At the end of our two visits you or your center will be paid $40 in appreciation for your time.

Your identity will, of course, be kept completely confidential. All of the data we collect will be given a code number and will not be identified by name. Access to the data will be restricted to people who work on the project. We will not be sharing the observations made in your center or home with [the child's] parents. The information we obtain will not be used for any purpose other than research.

You may withdraw your consent for the observation and you may refuse to answer any questions at any time without penalty. [We do not expect that it will ever happen, but we are required by law to report any incidents of serious abuse or neglect that we observe. THIS STATEMENT MAY NOT BE REQUIRED AT ALL SITES -- CHECK]

Signing this form indicates that the study described above has been explained to you, and that you voluntarily consent to participate. It also indicates that you have had an opportunity to ask questions and understand that future questions you may have about the research or about your rights as a participant in the study will be answered by one of the investigators.

Director/Care provider

Teacher/caregiver

Teacher/caregiver

Research staff member

Date

F. Materials Required for Child Care Assessments

The materials required for a child care assessment vary, depending upon whether the provider is a center-based provider, a family day care home-based provider, a babysitter, or a relative.

The child care visit checklist will help you determine which materials to bring to which type of visit. You may want to keep these worksheets on file at your site in order to have a record of when materials were submitted to your PC.

36-MONTH CHILD CARE OBSERBVATION SCHEDULE FACE SHEET AND CHECKLIST

CHILD ID______________________________ RA ID______________________

	DATE COMPLETED	DATE TURNED IN TO PC
CONSENT FORMS (CAREGIVERS, DIRECTOR)		
ORCE ROUND 1		
ORCE ROUND 2		
ORCE ROUND 3		
ORCE ROUND 4		
ORCE ROUND 5		
PROFILE (CENTER / FDC)		
HOME (FDC ONLY)		
DIRECTOR QUESTIONNAIRE (CENTERS ONLY)		
CAREGIVER INTERVIEW 1 (CENTER / FDC / FATHER)		
CAREGIVER INTERVIEW 2 (IF 2ND PROVIDER)		
CHILD CARE PROVIDER PACKET 1		
CHILD CARE PROVIDER PACKET 2 (IF 2ND PROVIDER)		
CBCL		
ASBI		
POST VISIT INTERVIEW AND RATINGS OF THE CAREGIVING ENVIRONMENT		
PROFILE MONITORING FORM		
MATERIALS FOR PEER OBSERVATION		
PAYMENT / RECEIPT		

G. Observation Schedule Face Sheet

OBSERVATION SCHEDULE FACE SHEET

CHILD ID #:____________________
CHILD NAME:____________________
DATE OF BIRTH:____________________
MOTHER'S NAME:____________________
FATHER'S NAME:____________________
HOME PHONE #:____________________
HOME ADDRESS:____________________
____

INTERVIEWER:____________________
DATE OF INTERVIEW:____________________
INTERVIEW WINDOW:____________________
ASSESS. WINDOW:____________________
COMBINED WINDOW:____________________

CHILD CARE ARRANGEMENT TO BE VISITED

NAME OF PROVIDER:____________________
NAME OF DIRECTOR (IF CENTER):____________________
NAME OF PROGRAM:____________________
ADDRESS:____________________
____
PHONE:____________________
DAYS / HOURS:____________________
DATE ARRANGEMENT STARTED:____________________
PROVIDER'S RELATIONSHIP TO BABY:____________________
OF OTHER CHILDREN PRESENT:____________________
______BABY'S HOME ______SOMEONE ELSE'S HOME ______CENTER

CHILD CARE RA:____________________
VISIT ONE DATE:____________________
VISIT TWO DATE:____________________
DIRECTOR INTERVIEW:____________________

CHILD CARE RA ID:____________________
TIME OF VISIT ONE:____________________
TIME OF VISIT TWO:____________________
CONFIRMATION LETTER:____________________
(INCLUDE DIRECTOR QUESTIONNAIRE IF CENTER)

PEER OBSERVATION:
PARENT PERMISSION OBTAINED__________
OBSERVATION COMPLETED (DATE)________
NOTES:

H. Child Care ID Worksheet

Child Care ID Worksheet

Observation Cycle #

Behavior Scales	Temporary ID*	Final ID Description**	REL	ASSIGN	QUALS?***	END OF VISIT	INT/QUES?
Caregiver 1							
Caregiver 2							
Caregiver 3							
Caregiver 4							
Caregiver 5							
Caregiver 6							
Caregiver 7							
Caregiver 8							

Observation Cycle #

Behavior Scales	Temporary ID*	Final ID Description**	REL	ASSIGN	QUALS?***	END OF VISIT	INT/QUES?
Caregiver 1							
Caregiver 2							
Caregiver 3							
Caregiver 4							
Caregiver 5							
Caregiver 6							
Caregiver 7							
Caregiver 8							

Observation Cycle #

Behavior Scales	Temporary ID*	Final ID Description**	REL	ASSIGN	QUALS?***	END OF VISIT	INT/QUES?
Caregiver 1							
Caregiver 2							
Caregiver 3							
Caregiver 4							
Caregiver 5							
Caregiver 6							
Caregiver 7							
Caregiver 8							

Observation Cycle #

Behavior Scales	Temporary ID*	Final ID Description**	REL	ASSIGN	QUALS?***	END OF VISIT	INT/QUES?
Caregiver 1							
Caregiver 2							
Caregiver 3							
Caregiver 4							
Caregiver 5							
Caregiver 6							
Caregiver 7							
Caregiver 8							

Observation Cycle #

Behavior Scales	Temporary ID*	Final ID Description**	REL	ASSIGN	QUALS?***	END OF VISIT	INT/QUES?
Caregiver 1							
Caregiver 2							
Caregiver 3							
Caregiver 4							
Caregiver 5							
Caregiver 6							
Caregiver 7							
Caregiver 8							

*Use A,B,C,D, etc.

**Use first name, appearance, etc. to assure you will keep this person consistently identified across observation cycles and days.

***Indicate whether the person is Caregiver 1, 2, or 3 for the Qualitative ratings conducted after each Behavioral rating cycle. If not considered in Qualitative ratings, leave blank.

I. CONFIDENTIAL WORKSHEET for Assigning Final Child Care IDs (not to be sent to Data Center)

Use this sheet to record final ID's and match them with actual programs and providers. This must never be sent to the Data Center and should be kept in the child's locked data file under the 36 month child care visit at all times, for completion and reference only by the PIs, Site Coordinators, and designated personnel.

In the case of center-based programs, record the name and ID of the director, and then record the names and IDs of all providers observed in this center. For all other arrangements, only names or providers will be recorded. This is the only way we will know when multiple providers were seen in a single arrangement.

When the same provider/center is used by more than one study child, USE THE SAME FINAL ID NUMBERS.

CONFIDENTIAL WORKSHEET CAREGIVER ID'S

Date ____________________

Child ID ________________

Name of Director ____________________	Temp. ID	Perm. ID
Name of Center ____________________	________	________
Name(s) of Provider(s) ______________	________	________
____________________	________	________
____________________	________	________
____________________	________	________
____________________	________	________
____________________	________	________

J. Profile Self-Monitoring Form (36T)

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K. Training and Reliability for Live Ratings

Becoming reliable on the qualitative and behavioral ratings, and on the Profile and the Child Care HOME, requires that observers (a) be extremely knowledgeable of the coding manuals, (b) apply this knowledge to the task of watching children and caregivers, and of rating environmental quality, and (c) use the same metric in their assignment of ratings as that used at the other nine sites.

The task of creating reliable raters across 10 sites as part of a longitudinal study is formidable. The successful implementation of the qualitative and behavioral scales is dependent upon observers in all the sites using the same "cut" points when they make their ratings. Similarly, it is crucial that observers code the Profile and Child Care HOME comparably.

But, there are many difficulties. Not all observers will be able to attend the live training. A method of training these people had to be found. Another difficulty is that consistency in ratings must be maintained over a 10-month period. Observer and site drift must be minimized. Also, because new observers may be joining sites as the study progresses, a way had to be found to insure that these new observers are trained in precisely the same way as previous observers. A final difficulty in this 10-site collaboration is that child care quality may vary systematically across sites, resulting in a different internalized metric at different sites.

For each of these reasons, we adopted a strategy of using comprehensive training films with accompanying text that can be used and studied at each site for the qualitative and behavioral ratings. The Profile and Child Care HOME measures cannot be captured on video, and require somewhat different training and reliability procedures, as described below.

1. Preparation of Training Tapes for the ORCE

An important component of training is for coders to experience the full range of child care settings and experiences. Therefore, videotapes of infants in day care centers, family day homes, nanny care, father care, and grandmother care were collected. Children were videotaped during feedings, diapering, play periods, and when they were left unsupervised. Children were also taped in child care situations that varied widely in quality. Diversity in terms of the children's and caregivers' ethnicity, race, social class, and geographic region was important. From this video library composed of many hours of tape representing ten sites in the network, training films for the qualitative and behavioral ratings were created. These films were created in order to expose coders to the greatest diversity in child care experiences within a reasonable period of time.

2. Training Procedures for the Qualitative and Behavioral Ratings

a. Qualitative Ratings

Training on the qualitative ratings goes through a progression of steps designed to prepare observers incrementally for their task.

Step 1 - Prior to beginning formal training coders are expected to be extremely knowledgeable of the coding manual. They should be able to define and know the four points of each qualitative scale. They should also be able to supply illustrative examples of each concept.

Step 2 - The next step of training is to illustrate via multiple taped snippets taken from diverse child care settings what is meant by each item on the scale. To this end, for the qualitative rating scale, there is a VIDEOTAPE illustrating both the positive and negative end of each scale. For example, this tape shows several instances of what we mean by caregiver sensitivity to distress, as well as, several instances of caregiver insensitivity to distress. Multiple exemplars of caregiver positive and negative regard, stimulation of development, and each of the other scales are also provided. Written text describing each snippet and coding decisions relevant to the snippet are to be reviewed prior to the child care training.

Step 3 - The third step of the training consists of learning the cut points for the scales (2-hour training module). To accomplish this trainees view eight 10-minute videotaped segments selected to expose trainees to a wide variety of child care settings. They are to make written notes as they view the segment. After viewing each segment, trainees independently rate the segment using the qualitative rating scales. Following their rating of a segment trainees compair their ratings to the master ratings provided and then written justifications given for each scale, i.e., reasons for the master codes. Trainees then view the segment a second time with the master codes available. Trainees then move on to the next 10-minute segment and go through the same process. Because these segments are supposed to familiarize the trainees with decision rules and cut points, high reliability may not be achieved on the scales, particularly in the first of the tapes being reviewed.

Step 4 - The next 3 hours of training (three 44-minute segments) enable the trainees to practice making ratings over 44-minute periods, the actual duration of their observations in the field. These tapes should be reviewed and rated prior to the child care training in Kansas.

Step 5 - Trainees should bring questions to the childcare training. One additional tape will be coded at the training. During practice, trainees assessments should be done independently, with trainees comparing their ratings and scores with the master ratings only after they made their own independent judgements. Trainees should carefully study the written justifications and explanations provided for each training tape.

Step 6 - Trainees should then practice doing behavioral and qualitative ratings at their home site using a variety (types and qualities) of child care settings on two post-training tapes. Ideally pairs of observers will make observations that they can compare at the end of 44 minute periods. A minimum of one visit per week should be completed during this practice period. Questions regarding these scales or coding decisions should be directed to Kathleen McCartney and Alison Clark-Stewart (behavior scales) or Deborah Vandell (Qualitative scales).

b. Behavior Scales

Step 1 - Before the training, designated trainees from each site will have memorized coding rules and definitions. Each site director is responsible for assuring that his or her trainees have memorized the manual prior to the training. Trainees should be prepared to pass a written test demonstrating their knowledge of the code when they come to the training.

Step 2 - The next step of training is to illustrate via multiple taped snippets taken from diverse child care settings what is meant by each item on the scale.

Step 3 - The third step of the training for the behavioral code consists of learning to identify relevant behaviors, (2 hour training module). This session has trainees view the same 10-minute videotaped segments used for the qualitative ratings. In this case, however, trainees will observe for behavior frequencies in 30 second intervals. The tape will be stopped and they will mark independently all relevant categories. Immediate feedback on a frame-by-frame basis will be given. After several tapes are scored in this way, trainees will watch and score entire 10-minute segments using the behavior scales. Agreement with the master coders will be determined after the whole segment is scored.

Step 4 - The next four hours of training (divided into two 2 hour sessions) enable the trainees to practice making observations over 44-minute periods, the actual duration of their observation cycles in the field. For this part of the training, trainees will complete the behavior scales for 30 minutes. They will observe and make notes for the qualitative ratings for 10 minutes. Qualitative ratings will then be made on a full 44-minute segment. Once again, verbal and written feedback in the form of the master coding decisions will be provided for each segment prior to moving to the next segment.

Step 5 - During the next part of the training observers are expected to review all of the training tapes and documentation. Then they are to practice doing "live" observations at their home site using a variety of child care settings.

3. Training Procedures for the Child Care HOME

Training for the 36 month Early Childhood Child Care H.O.M.E. will be accomplished in three phases. They are:

a. Individual Training

Each site will receive a manual and three tapes. The manual will contain the who, what, where, when, why, and how of administering the H.O.M.E. Each child care observer is responsible for learning this material. There will be two video tapes (with master score sheets and discussion) depicting actual visits with thirty-six month old children in a child care setting. A third tape will be a discussion of the instrument's items and their definitions.

b. Child Care Training

Judith Brisby, from the Arkansas site will conduct the training on the Early Childhood Child Care H.O.M.E. at the 36 Month Child Care Training Session in Lawrence, Kansas. At that training there will be a discussion of items and a clarification of their definitions. There will also be training in specific aspects of H.O.M.E. administration such as body language, probing in general, probing difficult items, and observer attitude and deportment. Help will be given concerning how to make certification video tapes.

c. Continuing Training

Throughout the 36 month assessment period, newsletters and information packets will be sent to all sites. This information will provide help with aspects of H.O.M.E. administration that have caused difficulties during visits and during visits where unusual situations have arisen.

4. Training Procedures for the Profile

Because the Profile is designed to capture the quality of the child's child care environment -- comprehensively defined -- videotapes do not lend themselves as the best method of training.

Deborah Phillips with the assistance of Annette Sibley and Martha Abbott-Shim, co-authors of the Profile instruments will provide the training. As part of the training, all items will be discussed in detail. In addition, all participating child care observers from each site will visit three preschool child care classrooms as a member of a team, to practice coding the Profile in a live child care setting. During the training, the teams of coders will compare notes and any questions that arise will be discussed. No inter-observer reliabilities will be obtained on this measure during the training.

5. Training Procedures for the Peer Observation

Training to conduct the peer observation will be given at the 36-month child care training. Before the training, each observer will observe videotapes of the procedure and will be asked to do two practice administrations of the peer observation. At the training, additional practice and videotapes will be provided.

6. Some Words About Getting Used to Being an Observer

There's no question: being an observer is a unique and often frustrating experience. At first, you feel frustrated because there are so many things happening and you have to figure out how to categorize and code them in a limited amount of time. But even after you have the coding system down pat, there will be frustrations because events will occur that you feel the coding system is not adequately capturing. Resign yourself to this fact. You are an imperfect recorder and the observation system is incomplete. We hope, though, that aggregated across different observation cycles, on different days, and with different children, the records you make will lead to a meaningful "big picture".

Another frustration is feeling that what you are observing is not representative of what usually goes on in the setting. It's an atypical day, or your behavior is influencing the caregiver's or the child's behavior. Again, resign yourself to this limitation of doing in-person observations. There undoubtedly are differences because of your presence. But if you are unobtrusive, inconspicuous, and unthreatening, it is possible for caregivers to relax and children to ignore you and go about their normal routines. Caregivers will probably try to be on their "best behavior" (children won't care), but even if they are, their "best behavior" will be revealing of their typical behavior and will discriminate among individuals. As Frederick Wiseman (documentary film maker extraordinaire) pointed out, when people know they are being filmed (or observed), they tend to behave in the ways they know best and feel most comfortable with, not in ways that are novel and unfamiliar. Atypical events and "bad days" will be hidden in the aggregation of data across cycles, days, and children.

You may also feel frustrated because you are doing the same thing over and over again (the same coding every minute; the same set of cycles and procedures). Avoid this frustration -- a kind of burnout -- by taking an interest in the overall events occurring in the setting, not just focussing on the minute-to-minute coding. Think about the "big picture" of day care quality. Look for unusual occurrences. Take an interest in individual children and caregivers. If you feel you are simply on automatic pilot, discuss this with your project coordinator. You may need a break or some more variety in your work.

Finally, you may feel frustrated because your role as an observer precludes normal interaction with the caregiver or the children during the observation. As an observer, you may look but not touch. At times, this may feel strange, strained, uncomfortable. You may feel that you are acting weird. This is something you'll have to get used to. Try to distance yourself from the ongoing events as if you are watching a movie -- just make sure it's a really interesting movie.

7. Becoming reliable with the ORCE, Profile, and Child Care HOME

a. ORCE Criterion Inter-site Reliability

Three times during the 36-month data collection, criterion videotapes must be independently coded using the ORCE by observers at each site. For the 36-month visits these tests will be October 29 - November 15, 1993; April 15 - May 3, 1994; and August 5 - August 29, 1994. Upon completion of their assessment, observers will send their rating sheets to the Data Center where inter-observer reliability will be calculated. The Data Center will compare individual observer's ratings for each scale against those for master coded tapes. The criterion tapes for the qualitative scales are to be scored by Deborah Vandell. Criterion tapes for the behavior scales are to be scored by Nancy Keefe (UNH) and Alison Clarke-Stewart (U.C. Irvine).

In general, when coding from videotapes for the reliability tests, do not code anything you cannot see. Do not infer anything. For example, if a caregiver is smiling but you cannot see if the child is smiling, do not code shared positive affect, unless you hear laughter. (Presumably if you were there, you could move to get a better view.) If the caregiver is off-screen and you can tell that she is talking to the target child, code this (but only if it is obvious.)

If a trainee fails to reach criterion on either the qualitative or behavior scales, the principal investigator and site coordinator for that site will be informed. Feedback as to problem areas will be provided. The trainee then has several weeks to study and prepare for a second criterion test. If this second test fails to reach criterion, the observer will not be allowed to make qualitative or behavior ratings.

b. Profile and ORCE Live Inter-Site Reliability Assessment

For the first time at 36 months, an inter-site reliability assessment will be conducted on the Assessment Profile and the ORCE. To conduct this assessment, each site will select one child care observer to visit one other site. Further, each site will recieve a visit from one observer from another site. Whenever possible, it is preferable that the child care RA who conducts the on-site assessemnt with a visiting RA be different from the child care RA who travels to the designated other site. For example, if observer A from Kansas conducts the visit with the traveling Arkansas observer, observer B from Kansas should travel to Temple. This maximizes the number of unique pairings of observers. For a site with 3 or more child care observers, those who participate in the inter-site "live" reliability assessments should be selected randomly.

To assure that each site has settled into its 36 month procedures, we recommend that these visits be conducted AFTER February 29, 1994. To avoid interference with the ORCE criterion reliability assessments, we further recommend that these visits NOT be conducted between April 1, 1994 and May 3, 1994 or between July 15, 1994 and August 29, 1994. Finally, to assure that the inter-site reliability assessments on the Profile and ORCE are NOT conducted at the very end of the 36 month assessments, we recommend that these visits be conducted BEFORE October 1, 1994. Within these constraints, each pair of sites may schedule these visits at their convenience.

We suggest the following pairing of sites, based on geographic proximity. In effect, this creates a round robin chain of visits:

Seattle goes to Irvine
Irvine goes to Kansas
Kansas goes to Arkansas
Arkansas goes to Temple

Temple goes to Pitt

Pitt goes to Western Carolina

Western Carolina goes to Virginia

Virginia goes to New Hampshire

New Hampshire goes to Wisconsin

Wisconsin goes to Seattle

During the reliability visits, 2 center-based and 2 family day care settings will be observed by the pair of observers, one from the home site and one from the visiting site. These visits may be conducted on either real subjects or non-subjects, but the non-subjects must consist of settings that care for 36-month olds.

These two observers will go together to the FIRST of the pair of child care visits (in the case of real subjects) or will conduct a mock FIRST visit (in the case of non-subjects). All procedures for the first child care visit should be followed. Both observers' score sheets for both the Profile and the ORCE are then sent to the Data Center so that live inter-site reliability scores can be computed from them. For data analyses, the "official" data for a given child are the scores submitted by the child's primary observer (to be designated at the site). If the subject being rated is NOT a regular study subject, this fact must be noted and an ID number assigned using an 8 in the second digit as the ID in place of the hospital code. The last three numbers must be assigned from a new set of numbers starting with 001.

Every reliability visit will follow this schedule:

Profile: Safety (homes) or Safety/Health (centers), Learning Enviromnet (homes and centers), and Physical Environment (homes and centers) Ratings	15 minutes
ORCE, Cycle 1	45 minutes
ORCE, Cyle 2	45 minutes
Profile: Curriculum and Interacting Ratings (homes and centers)	30 minutes
Profile Report Items	5 minutes

(*One observer is designated as the interviewer and both observers complete the items based on the caregiver's/director's responses.)

This procedure will produce a total of 40 inter-site "live" reliability assessments for the Profile and the ORCE (20 in centers and 20 in homes). Each site will have contributed to 4 center visits and 4 home visits (2 centers/2 homes on-site and 2 centers/2 homes off-site).

c. Live Intra-Site Reliability: ORCE, Profile, HOME and End of Visit Scales (Post-Visit Interview and Rating of Caregiving Environment)

Different procedures are required for centers and home-based settings. For centers, the two observers go together to the FIRST (this is a change form the 24-month assessments) of the pair of child care visits and complete two ORCE observation cycles, the Profile (observations and interview items), and End of Visit Scales. For family day care homes, the two observers must go together to BOTH (this is also a change) visits and complete two ORCE observation cycles, the Profile, the HOME, and the End of Visit Scales (only one End of visit Scale is required). For informal home-based settings, the two obervers must go together to the SECOND visit and complete two ORCE observation cycles, the HOME, and the End of Visit Scales.

The observers may compare their scores (a valuable source of continued training) -- but may not change them. Both observers' score sheets are then sent to the Data Center so that live intra-site reliability scores can be computed from them. For data analyses, the "official" data for a given child are the scores submitted by the child's primary observer (to be designated at the site). If the subject being rated is NOT a regular study subject, this fact must be noted and an ID number assigned using an 8 in the second digit as the ID in place of the hospital code. The last three numbers must be assigned from a new set of numbers starting with 001.

The following schedule of reliability visits should be followed. Three basic principles guide these schedules. First, each observer must be paired an equal number of times with the other observer(s). Second, the reliability visits for any given pair must be balanced across 3 types of care: Center, family day care, and informal home-based care. Third, the visits need to be dispersed across the 36 month data collection peiod.

Thus, for sites with 2 child care observers, the pair need to conduct reliability visits in 3 center-based settings, 2 family day care settings, and 1 informal home-based setting. A total of six pairs of joint ratings are obtained.

For sites with 3 child care observers the following scedule must be followed:

Pair AB visits 2 centers, 1FDC setting, and 1 informal home setting

Pair AC visits 2 centers, 1 FDC setting, and 1 informal home setting

Pair BC visits 2 centers, 1 FDC setting, and 1 informal home setting.

In this case, a total of 12 pairs of joint ratings are obtained, with each observer participating in 8 intra-site reliability assessments. It is also recommended that there be a randomization of pairings over the time period. To accomplish this, we suggest that you randomly order the following sets of 12 visits:

AB center I
AC center I
BC center I
AB center II
AC center II
BC center II
AB FDC
AC FDC
BC FDC

AB home

AC home

BC home

... which could creat an order, for example, such as:

BC FDC

AB center I

AC home

BC center I

AB center II

AB FDC

AC center I

BC home

BC center II

AC center II

AB home

AC FDC

d. H.O.M.E. Certification Procedures

The certification process for the H.O.M.E. will begin with child care observers studying the manual, newsletters, H.O.M.E. updates and training tapes.

1. Initial Certification

There are three criteria which must be met for initial certification to be achieved. They are:

1. Self Administration Video Tape - each child care observer will administer the child care H.O.M.E. in a child ca re setting. This entire administration of the

36 month child care H.O.M.E. will be video taped. (This may be done on a pilot or volunteer and need not include the other child care procedures.) This video tape will then be scored by the child care observer. Scoring should be based exclusively on what is obtained from the video tape, not on observations made during the visit that are not recorded on the tape. Each item on the score sheet should be scored "yes" or "no". A reliability score of 90% or greater with a master coder from the Arkansas site must be achieved in order to pass this portion of initial certification.

2. Reliability Test - a certification reliability video tape will be provided by the Arkansas site. Criterion scoring has been developed for each item based on information contained in the video tape. All items will be marked "yes" or " no". In order to be certified, a child care observer must be in agreement with criterion scoring on 52 of 58 items.

3. Interviewer Monitoring Form - this form is a checklist of observer behaviors to be reviewed in making an overall appraisal of the manner in which s/he administered the child care H.O.M.E. This form is completed by the master scorer when reviewing a child care observer's self-administration video tape. This checklist contains 14 items. It covers such areas as sufficient probing, failing to probe, leading and

embarrassing questions, pacing, visitor attitude, listening techniques, body language, etc. Each behavior on the checklist will be rated on a 5-point scale and an overall score derived. To achieve initial certification, a child care observer must score 55 out of 70 points on the rating scale and must receive no rating of "1" on any of the items. In addition, observers must have no less than 4 H.O.M.E. items that were neither seen on the tape nor discussed by the observer and no less than 4 items which were asked/discussed and scored based on the incorrect intent of the item.

One through three above must be met as specified in order to receive initial certification. Should one or more of the three areas not be passed, the observer must take a make-up test.

2. Make-up Tests

The Make-up test(s) taken will be determined by the test(s) failed. The procedures are:

1. Self-Administration Video Tape Failed - If the self-administration video tape was less than 90% reliable with the master scorer, but the reliability test tape and the monitoring form were passed, the observer will submit a second self-administration video tape and score sheet. If this procedure is not passed, data should not be collected.
2. Certification Reliability Video Test Failed - If the

child care observer does not match 52 out of 58 items with the criterion score, but the self administration video tape and monitoring form are passed, s/he will take a second reliability test. If the second reliability test is failed, the observer will repeat the entire initial certification process (a new self-administration video tape with score sheet and a third reliability test). If this procedure is not passed, data should not be collected on the H.O.M.E.

3. Monitoring Form Failed - If the monitoring form on any one of the four elements (total score of less than 55, a rating of "1" on any item, 4 or more items not discussed or seen on the tape and/or 4 or more items probed/discussed with the wrong intent) is failed, the child care observer must submit a second self-administration video tape with score sheet. If the second tape is not passed, data should not be collected.

3. Drift/Recertification Procedures:

Approximately mid-way through the 36 month assessment period, child care observers will take a drift/recertification test. Each site should designate one child care observer to be the site "expert" for the H.O.M.E. All other child care observers at the site will be considered "teammembers". The procedures for recertification are as follow:

1. Site "expert" - the person chosen to be the site expert

will make a video tape of him/herself administering the child care H.O.M.E. in a child care setting. The site expert will then score the video tape based exclusively on what is seen and heard on the tape. In order to maintain certification, the site expert must have a reliability score of 90% or greater with the master coder at the Arkansas site. The site expert must also meet all requirements for the Monitoring Form as discussed in A.3 above.

2. Site "team member(s)" - without having seen the site expert's score sheet or discussed the tape's contents, each team member will view and score the video tape made by the site expert. In order to achieve recertification, the team member must have a reliability score of 90% or greater with the master coder at the Arkansas site.
3. Scoring for both the site expert and site team members will follow procedures outlined for initial certification. The video tape, the expert's score sheet and those of the team members will be sent to the Arkansas site by the designated date.
4. Certification Reliability Test Tape - the Arkansas as site may choose to add a reliability test tape to the drift/recertification procedures. In the event this step is taken, each child care observer will take the test in the same manner as for initial certification.

Each observer must score 52 out of 58 items with the criterion score sheet in order to pass. If this test is added to the drift/recertification testing regime, sites will be notified and instructions will sent with the video test tapes.

5. Drift/Recertification Make-up Procedures - the site expert and the team member(s) must have a reliability score of 90% or greater with the Arkansas master coder in order to pass. If the site expert fails, s/he must submit a new self- administration tape and score sheet. If a team member fails, s/he will then submit a self-administration tape and score sheet. If a team member is reliable with the master coder at Arkansas but is not reliable at the 90% level with the site expert, s/he will accompany the site expert on 5 visits, scoring the H.O.M.E. which will be administered and scored by the site expert. The expert and the member should discuss and review items (from the site tape) which were not agreed upon before beginning these visits and after each visit. Copies of these score sheets (from both the expert and the team member) should be sent to the Arkansas site with in 3 days of the visit. If 90% reliability is not reached on those scores, the team member will submit a self-administration tape. Any child care observer who fails a drift test should not collect data until

make-up procedures have been passed.

4. Provisional Certification

On occasion, the Arkansas site may choose to award provisional certification to a child care observer. Provisional certification will not be awarded often or on a wholesale basis, but rather rarely and only on an individual basis. Awarding provisional certification will be based on the type and severity of errors. When provisional certification is awarded, procedures for remedial study and certification will be determined by the Arkansas site on an individual basis.

5. New Personnel

When new personnel join a site's child care team during the 36 month assessment period, initial certification procedures will follow those outlined above. Initial certification must be achieved before data can be collected.

6. Data Collection Improvement

Should the Arkansas site detect patterns of error on an individual or site basis, those patterns will be reported to the site coordinator and project directors, along with suggestions for making the necessary changes.

e. Profile Self-Monitoring Procedures

To assure that the Profile is conducted properly at each site, a set of self-monitoring procedures will be followed. The 36-month Profile Monitoring Form (See Appendix J) needs to be completed immediately after every Day 1 child care visit in centers and family day care homes. The Form serves as a constant reminder of the Profile procedures and a source of information about any unusual circumstances that occured during the Profile data collection. These forms should be sent to the Data Center along with the data forms.

DC Provider

FDC Provider

Baby Sitter in
Child's Home or
Other Informal
Home-Based Arrangements

Father

Mother as FDC
Provider

DC Provider

FDC Provider

Baby Sitter in Child's
Home or Other Informal
Home-Based Arrangements

Father

Mother as FDC
Provider

ADDENDUM TO CHAPTER 27.2
PEER OBSERVATION MANUAL

I. Questions and Answers Regarding the Peer Observation Procedure

1. Should preference be given to the study child's "close friend" or to children in the child care setting?

Preference is given to children in the child care setting regardless of relationship. If the child care setting has children who are "just friends" of the study child, but the neighbor is a "close friend", do the observation in the child care setting. The only exception would be if the children in the child care setting are "not friends" - it is not advisable to conduct the observation with unfamiliar children or children with whom the study child has problems. Typically, we would get around the former by having the criteria that children must have known each other for two weeks.

2. What if we get to the child care setting and find that the "close friend" is not there, but permission has been granted for other children who are either "just friends" or "acquaintances"?

It is more important to conduct the peer observation than to have the ideal peer. The relationship hierarchy is just a guideline to help RAs select a peer, it is not a strict rule. The only relationship that should be avoided, if possible, are "best friends" and "not friends". The hierarchy should be used in cases where RAs arrive at the setting and they have permission slips from the "close friends" and the "just friends" and a choice of which child to observe must be made.

3. Are there guidelines to follow for running the procedure in the study child's or peer's home - not a care setting?

The same procedures used in a care setting will be used for both the study child's and peer's home, as they have been found to work well in all three types of settings. If unusual complications arise, send them to the Kansas site.

4. How should the labels received from the DCC be used?

One label should be on the tape sent to Kansas and the other is for the tape kept at the site.

5. Will monitoring forms be used?

There is no formal monitoring scheduled for the peer observation since the Kansas site will be coding the tapes at their site and will, therefore, be able to check for the consistency and accuracy of procedures. If the Kansas site notices anything that violates the protocol they will complete a monitoring form and contact the site. Sites may use the monitoring forms to train new personnel, and if the sites would like to do internal monitoring that would be fine as well.

6. How should cousins be coded?

Code peers according to the level of friendship they have with the study child. A cousin could be a close friend, but also just an acquaintance depending upon how much contact they have with one another.

7. Should sites red flag cases in which there is only one peer who has known the study child since birth?

No, these cases do not need to be red flagged. This information will be captured in the Peer Observation Videotaping Report form by question #4: level of friendship and question #6: length of time they have known each other.

8. How should situations in which the children smuggle a toy into the playroom or when a piece is left from a preceding toy set be handled?

If this is noticed before the RA starts timing, then the RA should go back into the playroom and remove the toy. If the RA notices the toy after timing has begun, s/he should wait until the transition and then remove it.

9. What if the pen on the Magnadoodle comes off?

The pen by itself is not a safe object to have loose. If the pen cannot be tied back on securely, then a new Magnadoodle should be purchased.

10. What if the only peer available is also a study child?

According to page 3 of the manual, under the section: Selection of Peer, "If the only peer available is also a study child, the observation should be carried out and the tape flagged and marked with the ID's of both children." Thus, only run the procedure once with the two children, treating only one of them as the "study child". The first two toys can be coded for both children, the flashlight should be coded only for the first study child. Try to time the observation for the first child, but if both can be observed within the window, this would be better.

11. What if the procedure is not complete due to peer refusal?

If the procedure is not complete due to peer refusal, only restart the session with another peer if refusal occurs during the first two minutes of the Magnadoodle. If the peer refuses after the first toy is over half way through or completed you cannot conduct the session with a second peer (pg.27 of Chapter 27.2). This study child will have missing data for the other toys.

12. What if the parent(s) request a copy of the peer observation videotape?

It is okay to give the parents a copy of the tape, but you must get the study child's parent(s) as well as the peer child's parent(s) to sign a consent form authorizing the release of the tape.

II. Problem Solving

1. Children complain about the non-working flashlight.

Ignore initial complaints (1 - 3, depending upon the nature of the complaint), then say, "Those are the only flashlights I have. You'll have to play with those for a few minutes". If complaints continue, ignore them again. If they become persistent, say again, "Those are the only flashlights I have. You'll have to play with those for a few minutes while I finish my work." If complaints still continue, ignore them. If the children become disruptive or are completely unoccupied, follow the procedure described under #2 below.

2. Children are disruptive or involved in dangerous behavior.

Disruptions and dangerous behaviors that require immediate intervention include throwing toys either at each other or outside the playroom and aggressive behavior intended to hurt the other child (hitting, kicking, biting, pushing). The RA's immediate response should be, "Toys are not for throwing. They are for playing in the playroom." OR "In the playroom you do not hit (kick, bite, push). This is a time for play."

If the disruptive or dangerous behavior occurs again, stop that portion of the procedure and introduce the next toy. If the behavior occurs again, end the observation. Note that disruptive or dangerous behavior does not include fighting over a toy unless the fight involves a physical attack on the other child. Toy struggles are part of what we are interested in observing, and should not be interrupted unless the child is in danger. DO NOT suggest to children that they need to share, or provide a solution to a conflict.

3. Children see or hear observer and try to interact.

Usually this situation can be prevented by following the correct procedure for running the session, which is designed to minimize children's awareness of your presence. If the children do ask questions or try to attract your attention, it is best to ignore them. If after 20 seconds the children are still trying to attract the your attention, say, "It's time for you to play with the TOY now." and possible add, "I have to finish some work." DO NOT poke your head through the curtain or talk over the top of the enclosure to the children.

4. Children talk or try to play with camera or microphone.

Ignore them. The microphone can be unobtrusively held in place if necessary.

5. Children move out of the camera's view.

Move the camera to keep them in view. If it is not possible to keep both children in the picture, keep the camera on the study child. If possible, pan to the peer occasionally. DO NOT ask the children to sit down or move closer together or do anything else.

6. Child(ren) standing in front of camera for a considerable length of time.

This is a judgement call on the observer's behalf. Basically, it is important to get a clear picture of what is going on during the procedure. However, we do not want intervention if it distracts or disrupts play. If the children are talking to each other or playing, do not intervene. It is important to try to get their faces on the screen if they are standing up. If they are just standing there, however, and not playing or interacting, refer to the manual (Chapter 27.2, page 25) for suggestions on how to get them to reengage.

7. Toy is not in the picture.

Move the camera to capture both the children and the toy. If this is not possible, keep the children in the picture. DO NOT ask the children to move the toy or to move themselves.

8. Child becomes upset.

This is a situation where intervention is necessary. No child should be in a situation where she or he is clearly upset. This applies to both the study child and the peer. If this happens, stop the timer, go into the enclosure, and comfort the child. Say, "This is a time for you to play with TOY. Please sit here (indicating a slightly different location) and play." If the child cries or refuses strongly, try introducing the next toy. If your intervention works and the upset child calms down, follow the timing rules in #10 below for starting the session over. If the child continues to cry or to be upset, it may be necessary to end the session. If another peer is available in the setting wait five minutes and try again with the other peer. However, end this session quickly if the study child is the one who is upset and continues to be upset.

9. Children are not playing.

Children do not have to be playing with the toys provided to be engaged in interesting and codable peer interaction. If the children are talking with each other or exploring the playroom (including the camera and microphone), do not interrupt them. If the children are completely uninvolved and/or appear to be concocting a scheme that looks like trouble, wait about 20 seconds and then, if they are still not involved say, "This is a time for play. Please sit down and play with TOY." If another 45 seconds elapse and the children are still not involved with the toys or each other, or disruptive behavior is escalating, end that portion of the procedure and introduce the next toy.

10. Child has to leave the playroom.

Despite your best efforts to get children to the bathroom before the session begins, some children will wait until they are in the midst of playing before they decide they must absolutely go to the bathroom right now. Or, other situations may also arise that cause children to leave the playroom in the middle of the peer observation. The following guidelines should be used to decide how to continue the session.

* If less than three minutes has elapsed for a given toy, begin that toy episode over when the child(ren) return to the playroom.

* If more than three minutes has elapsed for a given toy, introduce the next toy when the child(ren) return to the playroom.

If the children ask to leave the playroom and say something like, "We are done now. We want to go.", wait 20 seconds and if the requests continue, respond by saying, "Play with the TOY for a few more minutes and then I'll bring another one" or, if they have the flashlights say, "Play with the flashlights for a few more minutes while I finish my work."

11. Child asks for another toy.

If children realize that the RA has several different toys, they will often ask for the next one. Ignore the first 1 to 3 requests, depending on how insistent they are. Then say, "You play with that one for a little longer, then I'll bring another one." If the children continue to ask, ignore them. If their requests become insistent say again, "You play with that one for a little longer, then I'll bring another one when I finish my work." DO NOT respond with a question because the child is likely to say "No."

12. Peer enclosure breaking down.

Some sites have reported that their peer enclosures are breaking down. It seems that the metal screws are tearing the cardboard and the sides are coming loose. If this occurs, try the following: (1) reinforce the holes with duct tape, (2) unhook the bungy cord when the enclosure is not in use in order to relieve pressure of the bolts on the cardboard, (3) use shorter screws. Also, cover the enclosure with plastic in case of inclement weather.

13. Parent(s) want to watch the children through the viewfinder as it is being taped.

It is strongly recommended that RA's do not let the parent(s) or careprovider(s) watch the procedure through the viewfinder as it is being taped. The observer needs to look through the viewfinder in order to conduct the procedure properly. What some sites have done in this case is tell the parent(s) or careprovider(s) that they can watch the tape on their VCR when the procedure is completed, or if there is no VCR, they can listen to the tape on the camera using the earphones for sound.

III. Filming Children of Color

At the child care training in Kansas, several sites had questions about techniques for filming children of color successfully. The Center for Research at Wellesley College, who has had a great deal of experience in filming African-American and Hispanic children, has offered some advice.

As many sites have noticed the white background of the playhouse tricks the camera so that the facial features of dark-skinned children are difficult to see. It has been suggested that using a neutral beige or "TV blue" (sky/robin's egg blue) background will correct this problem. VC's may try draping a beige or blue sheet or blue contact paper over the back of the playroom (as long as it isn't distracting). Another suggestion is using an enclosure that has not been covered - so that the background is just plain cardboard. It would be relatively easy to set up the playroom with the "inside out", so that the plain side is in and the white side is on the outside.

Another suggestion is to alter the lighting in the playroom. It has been found that lamps with shades produce the worst lighting for filming children with darker skin. If it's not too intrusive, VCs may want to ask the caregiver to remove the shade while the child is being filmed - as the bare bulb will produce better lighting.

IV. Miscellaneous Comments

1. The flow charts (pgs.46-49) in the current manual (12/22/93) are missing, please transfer the flow charts from the old manual into the current manual.

2. When conducting the peer observation in an alternate setting that is not a child care arrangement, use the same script as that which describes the procedure to the careprovider, Appendix A, page 54 of the manual.

3. Payment for the peer observation procedure has been left to the decision of the individual sites so each site needs to develop its own policy.

CHAPTER 27

SECTION 2

PEER OBSERVATION MANUAL

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CHAPTER 27

SECTION 2

PEER OBSERVATION MANUAL

I. OVERVIEW

A. PURPOSE OF THIS MANUAL

This manual describes the peer observation procedure which is part of the 36-month child-care protocol for the NICHD Study of Early Child Care. The manual also includes information regarding the selection of peers for the observation and obtaining permission from parents and, if needed, settings in which the observation is to be carried out.

The materials in this manual will be modified if necessary during training and data collection. Any suggestions for additions or amendments should be addressed to Aletha Huston, 36-month chair, at the Kansas site and to the Data Coordinating Center.

The information in this manual was prepared by the investigators at Kansas site, Marion O'Brien and Aletha Huston. Kathy Zima, Betsy McElroy, Ann Southerland and Yvonne Caldera participated in preparation of the manual and the development of the procedures described here. In addition, pilot work carried out by Deborah Vandell and Mark Bailey at the Wisconsin site and Deborah Phillips and Preston Britner at the Virginia site was very helpful in testing and refining the procedures. Initial suggestions from Cathryn Booth and Sarah Friedman as well as other members of the NICHD Study of Early Child Care Steering Committee are gratefully acknowledged.

B. PURPOSE OF THIS CHAPTER

The purpose of the peer observation procedure at 36 months is to evaluate children's competence in play with a familiar peer in terms of level of social interaction, extent and complexity of social pretense play, efforts to direct play, imitation, negative acts, and prosocial acts. The peer observation procedure involves observing the study child and a familiar same-sex playmate in a standard setting. If the study child is observed at a child care environment the children will be separated from ongoing activities so that the measurement of peer competence is minimally influenced by the quality of that setting. A complete description of the procedures for running peer observations appears as Part 2 of this manual.

C. SITUATIONS IN WHICH PEER COMPETENCE IS TO BE ASSESSED

The peer observation procedure will be included in the battery of 36- month measures for all children for whom an appropriate peer can be identified. In many cases, it will be conducted in the child-care setting that is observed during the regular child care visits. If the child is not in care or the observation cannot be conducted in the care setting, a peer observation should still be carried out. The observation may be conducted in the child's own home or a neighbor's home if the children typically play together on a regular basis, according to the study child's mother or in the laboratory playroom as long as the peer enclosure is used. If there is no appropriate peer available, the peer observation will not be conducted. Attempts should be made so that most study children are observed in the peer observation procedure. If no peer observation will be conducted, you must send a Missing Peer Data Report Form (DM-M) both to the DCC and the Kansas site.

D. SELECTION OF PEER

The criteria for the selection of a peer to be observed with the study child are:

a. In age range from 30 to 48 months

b. Same gender as STUDY CHILD

c. Has been acquainted with STUDY CHILD for 2+ weeks (preference given to children in the child care setting that we will be observing for the 36 month visit); it is not preferable to observe the study child's "best" friend, according to parents or child care provider or a peer the STUDY CHILD does not know.

d. Is not a sibling; does not live in same house as STUDY CHILD

e. Is not a subject in NICHD study unless no other peer is available. If the only peer available is also a study child, the observation should be carried out with that child and the tape flagged and marked with the IDs of both children.

The identification of peers available for observation will be made by either the study child's parent, the child-care provider or occasionally by an adult in charge of the alternate setting. Using parts 5D and 5E of the 35-month phone call, the parent will be asked a series of questions to identify one or several familiar peers fitting the above criteria. Parents will provide identifying information to project staff or will contact the peer's parents to assist in obtaining informed consent.

If the parent is unable to provide any key information necessary to identify appropriate peers, or is uncertain about contacting the parents of peers who are present in the primary child-care setting, the child-care provider will be asked about the availability of peers and assist in obtaining consent. These procedures, if needed, will be included as part of the first child-care visit.

If the peer procedure is to be carried out in a setting other than the primary child care setting the identifying information will be obtained either during the 35-month phone call from the mother or from the adult in charge of the setting.

Once available peers are identified, the staff member conducting the observation must select the peer to be observed. The age and gender criteria are crucial. After that, a peer who is familiar and a preferred playmate but not the study child's "best" friend is preferable. The order of preference following the Peer Grid (35D page 8) is: 1) close friend, 2) just a friend, 3) an acquaintance, 4) best friend, and 5) not a friend.

Complete information regarding the procedures for arranging peer observations appears as Part 3 of this manual.

II. THE PEER OBSERVATION PROCEDURE

A. GETTING READY

Fitting the peer procedure into the child-care visit

There are several options for conducting the peer observation either along with the child care visit, or as a separate visit. Sites can decide either on a case by case basis or for all subjects, which procedure to follow. The first option is to fit the procedure in the second child care visit. If this is to be done, the main point to remember is that the peer observation MUST be done AFTER the 4th ORCE cycle. Within this option, there are several ways to go about it. One option is to conduct three ORCE cycles during the first visit so that the peer observation takes place during the time when the 4th ORCE cycle would have been conducted on the second day. If this option is selected, the first child care visit will be significantly prolonged and the observer and the care provider should be alerted to this. It may be necessary to leave during the lunch hour and return in the afternoon to complete all the measures. Whatever the case, the first visit will be longer than previous first visits where three ORCE cycles were conducted because of the increased duration of the Profile at 36 months, and the need to ask the provider questions about the peer. The second child care visit following this portion should remain the same in length, as the peer observation merely replaces one of the ORCE cycles that is usually done that day.

Another option for conducting the peer observation within the child care visit is to conduct it after the last two ORCE cycles in the second day. There may be cases where the child arrives in child care early enough in the morning to allow time to conduct two ORCE cycles and then the peer observation before lunch. If this option is selected, the observer must insure that the child will be alert and happy for the first two hours that morning. Again, this option will prolong the second visit and the observer may have to leave and return after lunch to finish the other measures, i.e. interviews, pick up questionnaires, etc. If desired, a second observer could arrive at the setting right before the peer observation is to be conducted to complete this measure while the first observer completes the other measures. The first visit in this case remains intact.

The peer observation can also be conducted in a separate third visit to the child care setting. The first two visits would be conducted as in previous time points (24-month), and the peer observation would be scheduled as a third separate visit. Sites preferring to conduct the peer observations in the child care setting separately may do so, as long as this does not place an extra burden on the care provider and she/he is willing to do a separate visit that can be scheduled within the window. This visit can be carried out by a different observer primarily responsible for conducting peer observation, or by the original observer. The main point to keep in mind is the comfort of the care provider. Ask the care provider what she/he would prefer and if the separate visit is preferred rather than having two long visits, this option should be selected. In this case, the peer observation visit must follow the two regular child care visits.

If the peer observation is to carried out at the child care setting, the observer will explain the procedure to the provider and determine the availability of possible peers. The observer and the care provider will identify a suitable location to set up the playroom as well as the best times to do the observation. A script for explaining the procedure to the care provider can be found in Appendix A.

Another option is to conduct the peer observation in a setting other than the primary child care arrangement. This can be done in cases where there are no appropriate peers in the child care arrangement, the peers in the primary arrangement refuse, or the care provider does not wish to have a measure videotaped in the setting or refuses a third visit. In these cases, the peer observation should still be conducted in another setting if there are peers available. This other setting could be an alternate care arrangement, a mother's day out, the child's or peer's home, or even the laboratory playroom. Wherever the peer procedure is conducted, the portable playroom must be used (even in the lab).

A separate visit will be necessary whenever the peer observation procedure is conducted in a setting other than in the primary child care arrangement. Sites can choose to follow this option either on a case by case basis or with all children if parents are willing. The main concern about conducting the peer observation in a setting other than a regularly scheduled arrangement is that the visit will need to be scheduled with two families, increasing the chances for cancellations or no shows. That is, if the observation is conducted in a regularly scheduled arrangement, parents are already used to taking the children to that setting on a regular basis. If the procedure is carried out in a place the children don't normally go, the parents are being asked to go out of their way to transport the children, and may need to be involved in making arrangements for the observation.

Whatever option is selected, the goal is to conduct the peer observation with as many study children as possible. The peer observation is a very important measure of peer competence, one of the main child outcomes in this study. Every attempt should be made to carry out this procedure. Flexibility with regard to location and staffing is given to all sites to insure the observation is completed on as many children as possible.

The procedures described in this manual assume that the peer observation will be conducted as part of the child care visit (second day). Sites conducting the observation should use these procedures for obtaining peer parent consent as general guidelines only.

If the peer observation is to be conducted at the second child care visit, it is best to wait to schedule the second child care visit until consent is obtained from the peer's parent (see procedures for contacting peers' parents). The time between the two child care visits can be as long as two weeks. Attempts should be made to obtain consent from the peer's parents before the second visit is to be conducted. If a week has passed since consent forms were given to the peer's parents, and consent has not yet been obtained, schedule the second child care visit, but continue to pursue obtaining permission slips in hope that by the time of the second visit the forms will have been returned.

To increase the possibility of having a peer available for observation, it is a good idea to hand out permission slips to all possible peers. If no permission forms have been returned by the time of the second visit, and there are no other peers available in any other setting, ask the provider if you can schedule a third visit once the permission slips are returned.

If upon arrival at the setting, it is discovered that a peer's parent has returned the consent form, the peer observation should be conducted that same day if at all possible. It is important, therefore, to be prepared to conduct the peer observation procedure during the second visit and have with you all the materials needed for the procedure. For sites that will routinely conduct the peer observation on the second child care visit, it is recommended that the first day's visit always contain three ORCE cycles to insure the peer observation can be conducted on the second day. Or, if conducting the peer observation after two ORCE cycles on the second day proves successful, the first visit need not be altered. The main point to keep in mind is to be prepared to conduct the peer observation on the second visit at all times even if consent was not obtained before this visit.

In cases where permission from the peer's parent has been obtained, but the peer is not available on the scheduled day for the second visit, a third visit should be scheduled if the provider is willing. If you have obtained consent for more than one peer, then conduct the observation with any one of the children available whose parents have returned the consent form.

When Conducting the peer observation during the second visit, it should be done at the conclusion of the observational portion of the visit. In all cases, it should be conducted AFTER the fourth ORCE cycle. Fitting the procedure into the day can be flexible to fit the schedule of the children and the setting. In many centers, the best time to schedule the peer observation is during the time when the children are playing outdoors or in another room. The peer observation, however, can be done successfully in a room full of children, so this is not a requirement.

If the peer observation is to be conducted as a separate visit, there are several possibilities for obtaining consent from the peer's parents. For example, if the 35-month phone call suggests there are suitable peers in the child care setting to be observed, a description of the peer observation visit may be given to the provider at the end of the first child care visit, and the peer parent packet should be left with the provider for distribution to the peers' parents. Then, on the second child care visit, the observer should pick up the consent forms if they were completed and returned. From this point on, sites are free to develop their own procedures for scheduling the peer visit and/or securing the peers' parents consent form.

The timing of the peer observation as a separate visit should be within the 36-month window for data collection. If it will be carried out at the observed child care setting, it should be conducted as close to the child care visit as possible. If it will be conducted in an alternate setting, it can take place before or after the child care visit, as long as the visit remains in the window for data collection.

Materials

The following materials are needed to conduct the peer observation procedure:

1. A portable cardboard "playroom"

The playroom is used to enclose a play area in which the study child and peer are observed and videotaped. The folded cardboard playroom extends to approximately 5 x 3 feet and is flexible to fit into a variety of situations. The playroom is to be used in **ALL** observations, even in settings where a separate room is available for isolating the children. This playroom provides a standard setting for the observation, reduces interference from other children in the child-care setting, and prevents variation in the situation arising from distractions in the surrounding area. To maximize the visibility of the children on videotape, keep the playroom in a rectangular shape with the camera set up at one end. (See the instructional videotape from the Kansas site).

Each site will assemble their own playrooms from A.) materials sent by the Kansas site: sheets of folded cardboard to construct 3 portable playrooms (two to use and one for a spare), plastic nuts and bolts and a videotape with assembly instructions as well as B.) several items that they must purchase. For each playroom you will also need:

2 jumbo rolls of plain white contact paper

1 black cloth, 4.5 x 3.5 feet (J.C. Penney's sells black sheets)

1 package black velcro, adhesive backed, 18" long x 3/4 or 1" wide

3 bungie cords, 1 12" and 2 36" long (for transporting the playroom)

2. Camcorder with wide angle lens and a short tripod

The camcorder is mounted on a tripod and positioned behind the curtain at the opening of the playroom, with the lens extending through an opening in the black cloth curtain. The wide angle lens is a necessity to obtain a codable picture. We suggest a Spectral Star 52 mm Macro wide lens with adaptor ring. When mounted on the tripod, the bottom of the camera lens should be no more than 23 inches from the floor.

3. A unidirectional microphone

A unidirectional microphone (we recommend Radio Shack model #33-987c - - Realistic Highball Unidirectional Dynamic Microphone) is placed on the floor immediately in front of the curtain with the head facing the children. Depending on the microphone and camera being used, you may also need a headphone adapter that adapts plugs from 1/4" to 1/2" so the microphone can be plugged into the camera.

4. An inexpensive woven rag rug, approximately 22" by 40" is placed on the floor at the back of the playroom for the children to sit.

5. **Toys**

The toys used during the peer observation session will be provided by the Kansas site:

a. Magnadoodle (Tyco Co., model no. 4801)

b. Fisher Price Kitchen Set (model no. 2122)

Remove from the set the apron and the potholder

c. Two Rayovac Bedtime Buddies disposable flashlights (model no. HBLI-IBB)

Before the first session, leave one flashlight turned on until it no longer works. You will need to check it before each session to be sure that it is still dead. Keep the others in reserve. During the peer observation session, you need one working and one non-working flashlight.

6. **Bags for carrying toys**

A large tote-bag is needed to carry all the materials into the child-care setting. Also, a pillowcase or other lightweight mesh bag is needed to hold the kitchen set.

7. **Timer**

A digital stopwatch is needed to time the segments of the peer interaction observation.

8. **Erasable board**

An erasable board is needed to video record identifying information at the beginning of each peer observation. (If your video equipment has a character generator, you can do the labeling with it rather than with the board.)

9. **Earplug or headphones**

An earplug or a set of headphones (walkman-type) is needed to do a sound check at the beginning of each session.

10. **Folding camp chair or stool**

The camera operator needs to stay out of sight of the children during the session. A low folding seat makes maintaining visual contact of the children through the camera's eyepiece much more comfortable.

11. **Stickers**

To thank the participating children for their help, and all the other children in the setting for not participating, take along enough stickers so that each child enrolled can have one after the procedure has been completed. Be sure to tell the child-care provider you have stickers for the children and follow his/her directions as to how to give them to the children.

12. **Other toys**

If a second person will be available to help entertain non-participating children, or if your previous conversations with the child- care provider have suggested the possible need for something exciting for non-participating children to do, it is useful to have along some extra toys to keep the children occupied. Also, if you plan to invite other children in the setting to play in the playroom after the study child and friend, it is best to use non-study toys for them. Some suggested toys for entertaining the other children while the procedure is being conducted:

a. Tyco View Master Show Beam Cartoon Projector (model no. 3144) with Show Beam Cartridges.

b. Kodak Designer Desk (model no. 278).

c. Playskool Lights Alive (model no. 421).

d. Books.

Explaining the peer observation to the child-care provider

It is important to explain the peer observation procedure to the child-care provider in advance, and often you will need to re-explain just before you set up. It is also helpful to have the child-care provider or adult in charge of the setting tell the study child and peer what will be happening. During this conversation, you should also be sure to tell the provider what is expected from him or her during the observation.

A script for your use in explaining the procedure is found in Appendix A. It is not necessary to read this script word for word, but you should thoroughly cover all the topics.

Making the children comfortable

If the peer observation is being conducted in a setting that is not the primary child-care arrangement, or if you are making a special visit to do the peer observation and children seem particularly shy, spend 20-30 minutes watching or joining children's play in the setting to allow the children to get acquainted with you before setting up the playroom.

Also, while you are setting up the playroom and equipment, the children will be curious about what is going on. Be friendly and relaxed with them. Explain that this is a special playroom and that you have brought fun toys to play with. It is important to make the playroom seem exciting.

B. Conducting the Peer Observation Procedure

The peer observation procedure, in total, takes 40 to 45 minutes. It takes about 15 minutes to set up the portable playroom, the camera, and the microphone. The play session itself takes about 15 minutes, and cleaning up takes about 10 minutes. If other children want to play in the playroom, this will take additional time. If the observation is being done as part of a regular child-care visit, it is best to wait to bring in the playroom, camera and toys until after you have completed your fourth observation. This keeps any distractions or excitement to minimum until you are ready to begin setting up.

The sequence of toys is as follows:

1. **Magnadoodle** -- 4 minutes
2. **Kitchen set** -- 5 minutes
3. **Flashlights** -- 3 minutes

Setting up

Set up the playroom so it forms a rectangular shape (roughly) with the camera at the opened end (See videotape). Place the tripod-mounted camera so the wide angle lens extends through a hole in the curtain covering the opening. Be sure to adjust the camera's height and focus for an optimal recording (see section D., what the view-finder should show). Set up the camera as best as you can to minimize adjusting the camera once the children have begun playing, which results in poorer tapes to code and draws children's attention to the camera. Next, connect the microphone to the camera, and place it on the floor right inside the curtain with the directional head facing into the playroom.

Test the camera and microphone before beginning. Label the tape with the study child's ID number, the date of the observation, and the time of day by using the erasable board. Also include the observer number and a description of the target child (See section D. Videotaping Issues). Record these labels, while you are holding the board, read the same information, and walk out again. Stop the tape, rewind, and play the tape to be sure you are recording both picture and sound. In order to listen to the sound, you must have an ear-plug connected to the camera. Be familiar with where the audio jack is located on your camera.

Place the Magnadoodle on the rug on the floor of the playroom toward the rear. You want the children to sit by the back wall facing the camera.

Inviting the children to play

Once you are ready, tell the child-care provider and then the study child and peer that it is time to play in the playroom. Ask both children if they need to go to the bathroom. When they are ready, invite them to the playroom. Pull the curtain up and over the camera to make the entrance larger and let the children see what's inside. This also hides the camera and deters questions and curious hands. Start the camera at this point.

Be sure to go into the playroom with the children. Tell them to sit down next to each other on the rug, at the back wall of the playroom so that the Magnadoodle is in front of them and they are facing the camera. Don't hesitate to be directive with the children about where to sit. Preschool children are used to being given such instructions by adults, and will not think it's unusual for you to position them. Do not use suggestive statements such as "Can you sit here?" This only invites children to say no if they are hesitant at all. Do not tell them they can't move or suggest things for them to do with the toys.

After the children are settled, present the Magnadoodle to both of them by placing it on the floor, equidistant between the two children. If one child has already become involved with the toy, gently reposition it between them, saying, "I know this is a fun toy. Let me show you both all the pieces." Then demonstrate the three writing instruments. Follow the script and suggested comments in Appendix B.

Leave the playroom, close the curtain, and immediately start your timer so you will be sure to record the full time for each toy. Be sure to sit down so the children cannot see your head above the curtain or playroom wall. Watch the children throughout the session so you can monitor any behavior that might require your intervention, and so you can keep the two children and the toy on camera as much as possible. See Videotaping Issues in section D.

Some children will test whether you are there and paying attention by calling to you. Tell them, briefly: "I have work to do. You play now." Do not look over the walls of the playroom or through the curtain, or you will encourage continued interaction and peek-a-boo rather than peer play. Again, do not use suggestions as this invites interaction with the children.

Changing toys

When the children have played with the Magnadoodle for 4 minutes, it's time to change to a new toy. Keep the camera running during the transitions between toys, but do not worry if the curtain or your body block the view of the children.

Open the curtain, tell the children, "It's time to pick up the Magnadoodle and play with another toy," and go into the playroom taking the next set of toys, in their pillow cases or other container so they are hidden from the children. Be sure to enter the playroom completely rather than talking through the curtain or over the playroom walls. Do not praise the children or comment on their play. Pick up the Magnadoodle with all its pieces, and place it behind you, out of the children's reach. Reposition the children on the rug so they are seated next to each other by the back wall, as they were at the beginning of the session.

If you noticed that one of the children was particularly restless and unable to get interested in the first toy, this is a good time to ask if he or she needs to go to the bathroom. Do NOT ask a general question, such as "Is everything all right?" "Are you having fun?" or "Is anything wrong?" You do not want to offer any child an option to leave the playroom except to use the bathroom. (Of course, if a child is very upset or fearful, the session will be discontinued. See suggestions under Solving Problems section C).

Once the children are sitting, open the pillowcase or bag containing the kitchen set. Place the stove on the floor between the children and set the cups, pans, and spoons around it so each child can easily reach some of them. Follow the script for presenting the kitchen set in Appendix B. Do not name any of the pieces and do not use statements that may encourage fantasy play such as, "*The burners turn red and get hot*."

As you leave the playroom, be sure to take the Magnadoodle and the bag in which the kitchen set is stored with you. Start the timer immediately, and check to be sure both children and the kitchen set are visible in the camera view-finder.

At the end of 5 minutes of play with the kitchen set, again open the curtain, say "It's time to pick up the kitchen set and play with another toy," and go into the playroom. Do not make any comments about the children's play or praise them. Pick up all the pieces to the kitchen set and put them back in the pillowcase or bag. Reposition the children on the rug as before.

Get out the flashlights. Be sure you know which one works and which one does not. (They can be different colors, have different patterns, or one can simply be marked with a small piece of duct tape.) Follow the script for handing the flashlights in Appendix B.

Hand the working flashlight to the Study Child and the other flashlight to the peer. Say, "You can play with these for a few minutes." Leave the playroom and set the timer. Keep track of children's play through the view-finder.

Usually the child with the non-working flashlight quickly discovers it doesn't work and asks for help or whines. Sometimes there is some negotiation first. Your response, whenever the request or complaint comes, must be: "I'm sorry. I don't have any more flashlights. You'll have to play with those for a few minutes." In some cases, you may need to repeat this a second time. After that, it is best to ignore the child's complaints or requests.

At the end of 3 minutes, stop the camera, open the curtain, and tell the children they are finished. Now you can make a comment about the children's play if you wish. Something fairly neutral, like, "You really seemed to have fun in the playroom today." or "You really enjoyed these toys" is better than an evaluative comment such as "You really shared your toys well." If one child never got to play with the working flashlight and seems distressed, try to give him or her an opportunity to use it. This is not necessary in most cases, however, as children are usually ready to rejoin the others.

As the children leave the playroom, give each one a sticker unless the provider has asked you to handle stickers in another way. This is a good time to thank each child seriously, perhaps shake their hands, and say something like you hope to see them again.

Cleaning up

If other children in the child-care setting are insistent about playing in the playroom, let them play in pairs or small groups, depending on the number of children at the setting. We have often found that this is not necessary as the other children often show little or no interest in the playroom depending on where it's set up and whether they have been occupied with other activities. However, it is best to have one or two small toys available for them to play with, but not anything too exciting. While these other children are playing, you can be packing up the camera and microphone and getting everything ready to go. Give each child a sticker when he or she is finished, or follow the care provider's directions regarding stickers.

Finally, fold up the playroom and secure it with bungee cords. Be sure to thank the child-care provider and the children for their help before you leave.

Completing the Videotaping Report form and Reporting problems

After the procedure is done, you must complete the **Peer Observation Videotaping Report** (Form 36P). First, you must provide a description of the study child in order for the coders to be able to identify him or her from the peer. Be sure to include clothing and hair color. Next, you will ask the provider/adult in charge, whether the peer is a special friend of study child's, amount of time in hours per week the peer is together with the study child at that setting, how long they have played together in months at that setting and if it was a typical day for both children, ie., were either ill that day. This information that you obtain from the provider/adult in charge will be part of the official data regarding that peer. Demographic information about the peer should have been obtained from The Peer's Parent Consent Form. You will also need to complete the lower portion of the form regarding the start and stop times and any interruptions or terminations of the videotaped session. For setting ID use the number of the child care arrangement we observed if peer observation was conducted in that setting regardless of whether it was part of the second visit or a separate third visit. Mail the original to the Data center and a photocopy to the Kansas site along with the tape.

C. Solving Problems

In general, it is best to leave the camera and timer running unless an exception is noted.

1. **Children touch camera or stare at it.** Some of this is bound to happen and should be ignored. Only if children are touching the camera lens or putting toys against it in a way that you think is potentially dangerous or destructive should you intervene. Then, gently tell them to sit down on the other side of the playroom and play with the toys. This is a popular game with the flashlights and seems harmless, if irritating. Remember, the less interaction

you have with the children, the more peer interaction and play we will see.

2. **Children throw toys over the wall of the playroom.** The first time this happens, hand the toy back and say, "The toys are not for throwing. They are for playing in the playroom." If children throw toys out a second time, end that portion of the observation and introduce the next toy. Don't scold the children, but explain that the toys cannot be thrown. Make a note about the reason for the short session on the Peer Observation Videotaping Report Form.

3. **Children are playing with their backs to the camera.** It is important to see the interaction of the children. But it is even more important that they play un-self-consciously. Reposition children at the beginning of each segment only, do not interrupt their play to ask them to sit in a particular place. If children are standing up, ask them to sit down again.

4. **Children seem restless or bored or begin to wander around or become disruptive.** If children are not involved with toys or each other for a consecutive 20 seconds, say "This is a time to play. Please sit down and play with the toys now." If they continue to be disengaged, wait 45 seconds. Sometimes children will be involved in conversation that does not involve the toys; there is no reason to interfere with them unless they are disruptive. If no play has occurred during that time, end that portion of the observation and introduce the next toy. Make a note on the Peer Observation Videotaping Report Form about the reason for the short session.

5. **Children ask for caregiver or another child.** Reassure them that the caregiver is nearby, and that the other children are near. If children in the playroom call to other children, tell them the other children are busy doing something else, and that they'll get to play with them soon. Do this only once, then ignore the child if at all possible. If children in the caregiver's group call to children in the playroom, try to get the caregiver's help in quieting them.

6. **Caregiver wants to watch or interact.** Once the children are settled in the room, you do not want an adult's face visible over the top of the playroom wall. Explain in advance to the caregiver that the children will play better when not distracted by seeing her/his face. Ask that the caregiver move away from the playroom. If the caregiver seems very curious, offer to let him or her watch through the camera view-finder for a little while. Also, assure the caregiver that you will be watching the children and will intervene if necessary.

7. **One child hits or throws something at the other.** You are responsible for the safety of the children. If you see either child doing something that could do physical harm, you must intervene immediately. If a child hits another child hard enough to hurt or throws something at the other child's face say, "In the playroom, you do not hit (throw things)." If the injured child cries pause the timer, step in to try to sooth the child and if needed obtain help from the care provider to comfort. If the injury is minor and the child is willing you may start the timer

and resume the session. If the same thing happens again, remove the toys and offer the next toys. If there are any more repetitions, terminate the session. Indicate on the Peer Observation Videotaping Report Form the reason for the interrupted or shortened session.

8. **A child becomes upset and cries.** You will need to use good judgment here. The procedures can produce mild distress, but if a child seems visibly upset or cries for more than a few seconds (about 15 to 30), pause the timer and step in and try to solve the problem. If children who are clearly upset or fearful want to leave the session, let them do so. No child should be asked to continue to participate if it is clear that he or she is truly uncomfortable or fearful. If at the beginning of the observation the selected peer is unwilling to participate but the study child is willing and another peer is available (with parent consent), you can substitute the second peer and conduct the session. This can be done **only** if the first peer refuses to continue during the first couple of minutes of the first set of toys. If the peer refuses **after** the time period for the first set of toys is completed you CANNOT conduct the session with a second peer. The peer observation would not be done for this child. If either of the children refuses to continue **at any time after** the magnadoodle, you should still send the data to the Kansas site for coding with explanation as to the termination of the session on the Observation Videotaping Report Form.

9. **Other children in the setting are upset because they can't be in the playroom.** Try to arrange for the caregiver to have a special activity for the other children. If needed, have the caregiver explain to them that they may have a turn. After the session with the peer and study child is over, let the other children play for a few minutes in the playroom while you are packing up the equipment.

10. **Children request another toy.** Sometimes children will say they're through with this toy and ask for another before the time is over. Ignore the first request. If they repeat it, say, "*You can play with that one for a little longer. Then I'll bring another one.*" It is also a good idea to keep the toys hidden while the children are entering the playroom so they do not know what else is available for them to play with. If the children ask for something else while playing with the flashlights, just ask them to play a little longer. If at any time the children become disruptive, end the segment after 45 seconds of no play (see #4 above). Be sure to indicate the reason for the shortened session on the Peer Observation Videotaping Report Form.

11. **Child says that s/he needs to go to the bathroom.** Even though you ask the children before they enter the playroom whether they need to use the bathroom, this does not insure that they won't decide latter that they do need to go. Pause the timer and take the child to the restroom. It is a good idea to ask again the other child whether s/he needs to use the bathroom also, in order

to minimize further interruption. Be sure to restart the timer and resume the play for that toy.

12. **Setting is too small for playroom to fit.** You may conduct the observation anywhere the provider suggests. This can be in the hall, another room, an office, a staff lounge, or another classroom. It is even possible to set up the playroom outside, on the porch, patio, garage, etc. as long as the weather is good and the caregiver is willing. If you cannot find any place to set up the playroom, do not do the observation. It may be possible to arrange the observation at the study child's home on another day. You must use the playroom for every setting. Check Peer Grid after returning to the office for any available peer at an alternate setting, then follow the procedures described in section C of part 3 to obtain parental consent.

D. Videotaping Issues

Filming identifying information on the tape.

As part of the setup procedures, film a sign on which you have written 1) " 36 Month Peer Interaction," 2) subject ID number, 3) date of video, 4) the approximate time started, 5) observer ID#, and 6) identifying information for the study child in order to distinguish study child from peer (e.g. blue T-shirt, blond hair, glasses). (This latter piece of information is very important in order that the coders code the correct child.) Make sure the correct ID number and identifying information are written on the sign.

This information is written on the erasable board you bring to the visit, unless your camera has a character generator. Film the board while you read out loud the same information. Rewind the videotape and play it back, using the earplug to check the audio, watch the video through the view-finder on the camera to be sure that both are recording properly.

What the view-finder should show

Keep both children in view, if at all possible. The children's whole bodies should be in view so that we can see what they are doing with the toys. Stay close enough to be able to see facial expressions, but not so close that you miss gestures, body positions, etc. In other words, try to frame the picture with the two children close to the perimeter, trying not to leave empty space on top, below, or on either side of the children. If, during the course of the interaction, both children move so that they cannot be in the picture simultaneously, keep the study child in view, zoom out as much as you can to try to get the other child in the picture while still getting the study child's facial expression. If necessary, pan back to the other child periodically. The wide angle lens should greatly help with this problem.

Both children need to be in focus. It is advisable to use manual focus rather than automatic focus. In order to focus the camera properly in the manual mode you need to first zoom all the way in on an object located where the children will sit. With the camera zoomed in all the way, adjust the focus ring to get a clear picture, then zoom back out to the proper distance for filming. It is important to be very familiar with the instructions manual for each camera, especially the instructions on how to adjust the manual focus. If you prefer to use the automatic focus, you need to make sure to adjust the focus whenever the children get closer to the camera and then move back. We advise against using the auto focus, as too much tinkering with the camera may call attention to the camera and away from the toys.

Number of observations per tape

It is more economical to put two observations on each videotape. However, the danger in this procedure is that more data would be lost if something happened to the tape. For this reason, we recommend that sites use one tape per peer interaction. When a copy is made (to be retained by the site) multiple observations can be placed on one tape. If you must put multiple observations on one tape, you must limit the number to two.

Labeling the outside of the tape

Tape identification information should be on each tape and tape box. It is important to label the outside spine of the tape and the box. The DCC will provide each site with labels containing the following information:

NICHD Study of Early Child Care
36-month Peer Interaction
Site
Family's ID#
Observer ID#
Target Child's Identifying Information (to be completed by the site)

Date of taping (to be completed by the site)

Do not include any other identifying information on the box or on the tape. Double check that subject ID is correct and matches the ID filmed prior to the interaction procedure. Each tape must be checked before mailing to the Kansas site for coding.

Copying the tape and mailing it to be coded

Each site should work out a process whereby a copy is made of each videotaped interaction. The copy should be retained at the site and the original should be mailed for coding to the following address:

Dr. Marion O'Brien
Department of Human Development
4001 Dole
University of Kansas
Lawrence, KS 66045

Include a photocopy of the Videotaping Report Form for each tape mailed to notify coders of interruptions or unusual circumstances that occurred. Also include a "Peer Interaction Video Shipping List (Form 36V)" listing all the tapes enclosed. The tapes should be mailed weekly. There is no need to use Express mail. Mark **Do Not X-Ray** on the outside of the mailing box. Sites will be notified when and what tapes (by subject ID) are received. Notify Marion O'Brien immediately if there is a discrepancy between what was thought to be mailed and what was said to have been received. If no peer observation was conducted, you must mail a Missing Peer Data Form to the DCC and to the Kansas Site. If the visit was terminated, complete Form 36P indicating this. Send Form

36P to the DCC and to the Kansas site; no missing Peer Data Form needs to be filled out in this case.

E. Training

The goal of training child-care visitors to videotape the peer interaction is to ensure that the tapes document peer interaction in a way that enables independent scorers to rate the interaction. Picture quality and sound quality must be excellent. Training on videotape technique using examples of what constitutes acceptable and not acceptable videotapes of peer interaction will occur during the training session on the 36- month child-care visit. Each trainee should become familiar with the site's video equipment prior to the training. In addition, each trainee must follow the certification procedures established for the peer interaction procedure. All personnel who subsequently become child-care visitors during the course of the 36-month data collection must review the training materials from the network training session and be certified on the peer interaction procedure. More detailed information about certification will be provided in separate mailings to sites.

III. ARRANGING PEER OBSERVATIONS

Part 5D of the 35-month phone call and the Peer Grid are designed to elicit enough information from the mother to determine if there is a peer available that meets the criteria for observation. Using part 5E of the 35-month phone call and the Peer Information

Worksheet will set into motion one of the four routes to obtaining permission to do the peer observation procedure (see flow charts at the end of this part). The first, and preferred approach is to obtain from the study child's mother the peer's parent's phone number and address and permission for us to contact the parents directly. The second approach is for the study child's mother to make first contact with the peer's parents and obtain their permission for us to call, then giving us their phone number and address. When this is not possible, the next approach is to enlist the help of the study child's care provider during the first child-care visit. If the study child has no primary child care setting or there are no appropriate peers in the primary child-care setting, the fourth is to contact the adult in charge at an alternate setting in which the study child regularly plays with one or more peers who fit the criteria for observation. Each of these routes to arranging the peer observation will be described in this section.

Because of the varied approaches to obtaining consent from peer's parents, it is important to keep track of these steps by marking the appropriate boxes on the Peer Information Worksheet. The Peer Information Worksheet and instructions can be found in Appendix D. of this manual. It is recommended that sites assign a person responsible for overseeing and tracking the peer selection process.

It is also recommended that two to four peers fitting the criteria be identified and permission for their participation obtained. This way, a backup is likely to be available if one of the peers is not in the setting on the day of the visit. When more than one peer is identified and permission requested, parents must be informed that their child may or may not actually be asked to participate; otherwise, parents may be disappointed that their child was not selected.

A. Getting Information From The Study Child's Parent

As part 5D of the 35-month phone call, the study child's mother will be asked to identify peers in the study child's primary child-care setting, alternate setting, or any other peers fitting the criteria for observation. To be observed with the study child, peers must meet the criteria listed on page 2 of this manual. The portion of the 35-month call in which peer information is requested is described in Appendix C of this manual.

First Approach: Mother provides sufficient key information to determine a peer

During the 35-month call, if the mother can provide sufficient key information necessary to determine availability of peers, the caller will next use part 5E of the 35-month phone call and the Peer Information Worksheet to record contact information for two peers who are potentially eligible for observation. Instructions for use of the Peer Information Worksheet are found in Appendix D of this manual. It is best to get information about peers from the study child's mother if at all possible, because care providers are usually not legally able to give out personal information regarding the children in their care.

The peers' parents name, address and phone number provided by the study child's mother will be followed up by calls to the parents of two peers if possible, asking their permission to have their child participate in the peer observation. A phone call script to use when contacting peers' parents appears as Appendix E to this manual.

Once the peer's parents have given their verbal consent, the Parent Permission Packet containing a cover letter with information about the study and the procedure, and two copies of a permission form are mailed to them, along with a stamped self-addressed envelope for return of one copy of the permission form (Appendix F). This packet can be sent out directly, without the phone contact (Appendix F1), in cases where peers' parents do not have telephones or they are unable to be reached after several attempts. In all cases, if the signed copy is not returned within a week, a follow-up call to the peer's parent must be made. If the peers' parents do not have telephones and the consent is not received within a week, begin the procedures for determining the availability of another peer by enlisting the help of the child-care provider, or the adult in charge if an alternate setting has been chosen. **The signed consent form must be obtained before the peer observation can be carried out.**

If the study child is in observable child care, the first child-care visit should not be scheduled until an effort has been made to contact parents of peers named by the study child's mother in the 35-month call unless the peer observation will be conducted as a third visit. Thus, these efforts should be made within the week following the 35-month call in order not to delay the child-care visits past the window for data collection. If peers' parents cannot be contacted or do not give permission for their child's participation, then the first child care visit should be scheduled and the child-care provider must be enlisted for help in contacting other parents. The recruitment of help from the provider is done at the first child-care visit (see Part B of this section). If peers' parents have been contacted by phone and have given verbal consent, the first child-care visit can be scheduled. If the peer observation is to be conducted as part of the second child-care visit, the second visit cannot be scheduled until the peer consent forms have been returned. If one week has passed since the first child-care visit and the forms have not been returned you should schedule the second visit as soon as possible such that the length of time between visits is no more than two weeks. If the information from the Peer Grid indicated that there is another peer who might be observed in another setting, then proceed to contact that peer's parents (for suggestions see Problem Solving, part 4).

Second Approach: Mother wants to make first contact with peers' parents herself

At times, the mother will want to make the first contact with peers' parents. In this case, encourage her simply to get the peers' parents permission for us to call or to send them a packet.

Also ask her when she thinks she might be able to talk with the peers' parents, and be somewhat insistent on a follow-up date. You can politely but firmly explain that we must complete the observation within a certain timeline, and need to move forward with getting permission from the peer within the week. Follow up this first call no more than a week later. If the mother has not yet contacted the peers' parents, remind her and thank her, but move on to the step of enlisting the child-care provider for help in contacting peers' parents.

If at the call-back the mother has talked with the peers' parents and they are agreeable to being contacted, obtain the phone number and address and call the peers' parents directly, using the script in Appendix E. As part of this phone call you will be confirming the information regarding the peer that the study child's mother provided during the 35-month phone call. If this information contradicts the information from the mother and the peer does not meet the criteria, we will not observe this peer with the study child (for suggestions see part 4, Problem Solving). If the parents give verbal consent, follow up with a parent permission packet (Appendix F2). If the signed consent form is not returned within a week, follow up with a phone call to the peers' parents.

If the study child is in observable child care, the first child-care visit should not be scheduled until the study child's mother has been called back and any information provided about peers followed up. If the peers' parents cannot be contacted or do not give permission, proceed with scheduling the first child-care visit and enlisting the help of the child-care provider to determine the availability of other peers (Part B of this section). If peers' parents have been contacted by the study site and have given their verbal consent, the first child-care visit can be scheduled. If the peer observation is to be conducted as part of the second child-care visit, this visit cannot be scheduled until the signed permission form has been returned to the study site. If one week has passed since the first child-care visit and the forms have not been returned you should schedule the second visit as soon as possible such that the length of time between visits is no more than two weeks. If the information from the Peer Grid indicated that there is another peer who might be observed in an alternate setting, then proceed to contact that peer's parents (for suggestions see Problem Solving, part 4).

B. Identifying Peers Through The Child-Care Provider

Sometimes the study child's mother will not be able to provide key information necessary to determine the availability of peers in the child-care setting, or will not want to give out that information to you. Sometimes mothers will offer to get the information for you, but when you call back they will not have done so. In these cases, if the study child is in observable care, part of the first child-care visit will involve getting information about the availability of appropriate peers from the child-care provider and enlisting his or her help in getting parent permission.

Third approach: contact with peers' parents will be made through the child-care provider

At the end of the first child-care visit, the visitor will briefly explain the peer observation procedure to the provider, ask about the availability of peers fitting the criteria for observation using the Peer Information Interview for Child Care Providers and if there are available peers request that the provider give parent permission packets (Appendix F-3) to at least two appropriate peers. Information concerning the Peer Information Interview for Child Care Providers appears as Appendix G to this manual. If the observer senses that bringing up a videotaped procedure will jeopardize collecting the remaining child care data, no mention should be made of the peer observation, and the second child care visit should be scheduled.

If appropriate peers are identified and the provider agrees to give out the packets, request that the packets be given to parents that same day if possible. If the provider does not plan to give the packets out that day, or if the identified peers are not in the child-care setting that day, ask the provider when he or she thinks the packets will be delivered. If signed consent forms have not been received either by the care provider or at the study site within one week from that date, follow up with a phone call to determine if the packets were given out and if the parent has the signed consent forms. If the peer observation is to be conducted as part of the second child-care visit, that visit cannot be scheduled until the signed consent forms are received (or one week has passed since the first child-care visit).

C. Identifying Peers In An Alternate Care Setting

If the study child is not in observable care, if there are no appropriate peers in the study child's primary child- care setting, or if permission to observe peers is not obtainable, the peer observation can still be done if the child regularly plays with a peer fitting the criteria. This may be a part-time child-care arrangement that does not meet the study's criteria for child-care observation, an informal parent-led play-group, the study child or peer's home where they frequently play, or even the laboratory playroom. (These are simply examples of possible settings; any setting in which the study child and a peer meeting the criteria for peer interaction observation can be observed is a possible setting.)

Fourth approach: peer observation is initially picked to be conducted at an alternate setting

If a.) the study child does not have a primary child care setting or b.) there are no peers that meet the criteria for observation at the primary setting, then the peer observation must be conducted at an alternative setting, provided there is a peer meeting criteria available. The availability of peers in such a setting will be determined during part 5-D of the 35-month phone call on the peer grid. Using part 5-E of the 35- month phone call and the Peer Information Worksheet information on peers in an alternate setting will be recorded. If the mother provides the peers' parents name, address and phone number, you will call the peer's parents directly using the script in Appendix E.

Once the peer's parents have given their verbal consent, the Parent Permission Packet containing a cover letter with information about the study and the procedure, and two copies of a permission form are mailed to them, along with a stamped self-addressed envelope for return of one copy of the permission form (Appendix F). This packet can be sent out directly, without the phone contact (Appendix F1), in cases where peers' parents do not have telephones or they are unable to be reached after several attempts. In all cases, if the signed copy is not returned within a week, a follow-up call to the peer's parent must be made. If the peers' parents do not have telephones and the consent is not received within a week, begin the procedures for determining the availability of another peer by enlisting the help of the study child's parent or an adult in charge of the setting, if appropriate. If the alternate setting is the study child or peer's home, consent for observation can be obtained at the beginning of the visit, prior to the start of videotaping. **The signed consent form must be obtained before the peer observation can be carried out.**

If the mother is unable to provide contact information for the peer, enlist the help of an adult in charge at the setting when you call to request permission to do the observation.

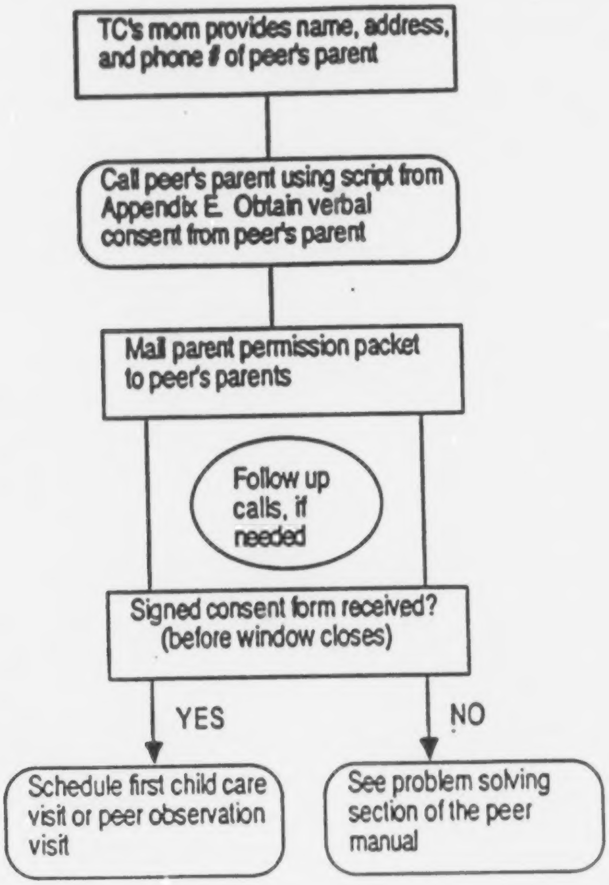
If the observation is to be carried out at an organized child care setting, make the initial contact with the alternate setting by phone. A script for this phone call is included in Appendix H of this manual. If the availability of peers has not yet been determined, use the Peer Information Interview For Alternate Settings with the adult in charge, which can be found in Appendix I of this manual.

If appropriate peers are identified and the adult in charge agrees to give out the packets, request that the packets be given to parents that same day if possible. If the adult in charge does not plan to give the packets out that day, or if the identified peer is not in the setting that day, ask the adult in charge when he or she thinks the packets will be delivered. If signed consent forms have not been received either by the adult in charge or at the study site by one week from that date, follow up with a phone call to determine if the packets were given out and if the parent has the signed consent forms. The visit cannot be scheduled until the signed consent forms are received.

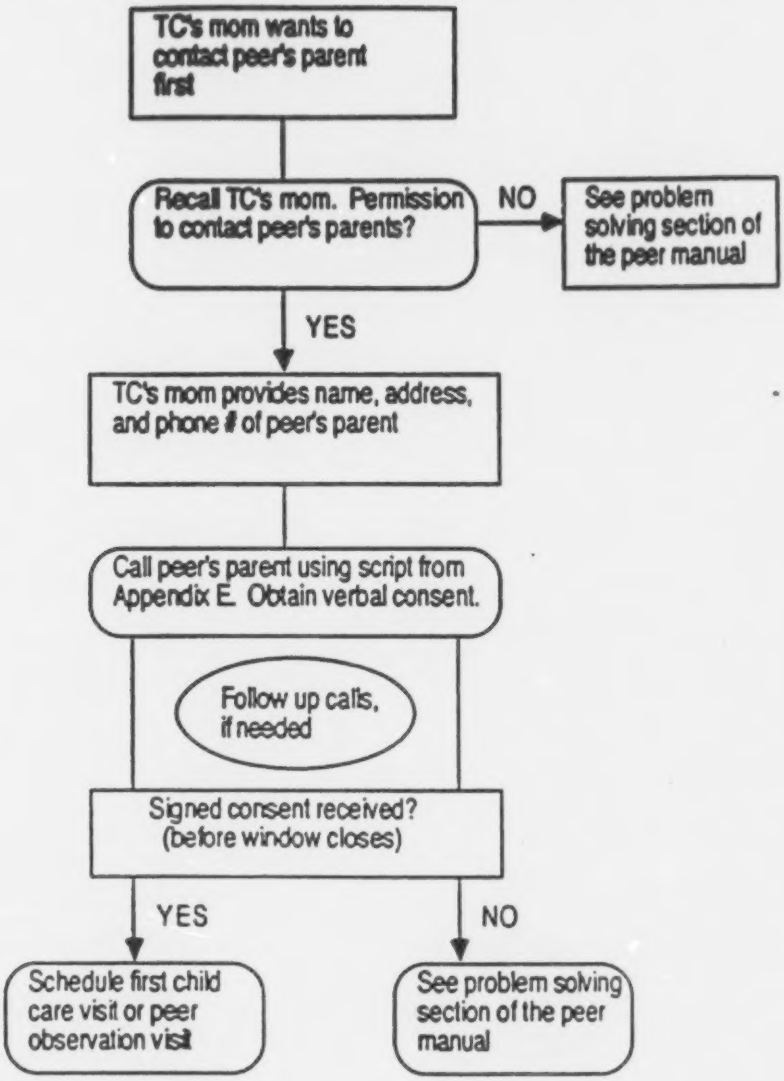
Choosing an alternate setting when conducting the observation in primary setting falls through. Sometimes circumstances (as noted in the problem solving section) make it impossible to conduct the peer observation in the primary childcare setting even though there may be peers at that setting. Your fall back position is to try to conduct the peer observation with a peer at an alternate setting, which may be the study child or peer's home. As mentioned above the availability of other peers will be determined during part 5-D of the 35-month phone call. However, you may need to call the study child's mother if any information necessary to contact the parents of these peers is missing and explain to her why more complete information has become necessary. Use either script E or H depending on whether you are making first contact with the peers' parents or with the adult in charge and be sure to complete the necessary follow up steps. If the study child's mother was unable to provide any key information necessary to determine whether the peer met our criteria, then use the Peer Information Interview for Alternate settings with the adult in charge, or call the peer's parent directly to determine whether he or she is appropriate for the observation.

As above, if appropriate peers are identified and the adult in charge agrees to give out the packets, request that the packets be given to parents that same day if possible. If the adult in charge does not plan to give the packets out that day, or if the identified peer is not in the setting that day, ask the adult in charge when he or she thinks the packets will be delivered. If signed consent forms have not been received either by the adult in charge or at the study site by one week from that date, follow up with a phone call to determine if the packets were given out and if the parent has the signed consent forms. The visit cannot be scheduled until the signed consent forms are received. The exception is the situation where the peer's parent will be present during the observation. In this case, the signed consent may be obtained immediately before conducting the observation. Remember that the peer observation must be completed before the exception window expires and often times in these situations many weeks may have elapsed since the study child's 36 month birthday.

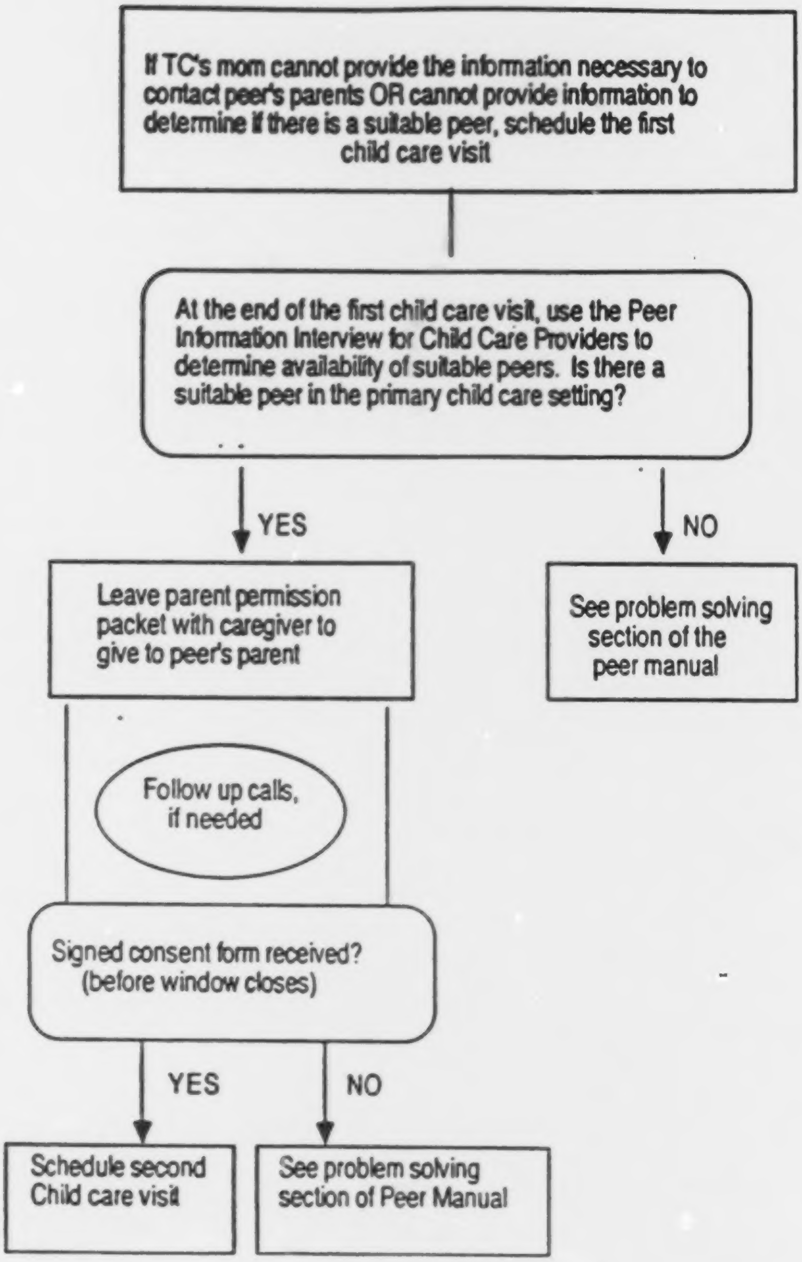
PREFERRED APPROACH TO OBTAINING PEER PARENTAL PERMISSION:


TC's mom provides name, address, and phone # of peer's parent
Call peer's parent using script from Appendix E. Obtain verbal consent from peer's parent
Mail parent permission packet to peer's parents
Follow up calls, if needed
Signed consent form received? (before window closes)
YES
NO
Schedule first child care visit or peer observation visit
See problem solving section of the peer manual

SECOND APPROACH TO OBTAINING PEER PARENTAL PERMISSION:


TC's mom wants to contact peer's parent first
Recall TC's mom. Permission to contact peer's parents?
NO
See problem solving section of the peer manual
YES
TC's mom provides name, address, and phone # of peer's parent
Call peer's parent using script from Appendix E. Obtain verbal consent.
Follow up calls, if needed
Signed consent received? (before window closes)
YES
NO
Schedule first child care visit or peer observation visit
See problem solving section of the peer manual

THIRD APPROACH TO OBTAINING PEER PARENTAL PERMISSION:



If TC's mom cannot provide the information necessary to contact peer's parents OR cannot provide information to determine if there is a suitable peer, schedule the first child care visit

At the end of the first child care visit, use the Peer Information Interview for Child Care Providers to determine availability of suitable peers. Is there a suitable peer in the primary child care setting?

Leave parent permission packet with caregiver to give to peer's parent

See problem solving section of the peer manual

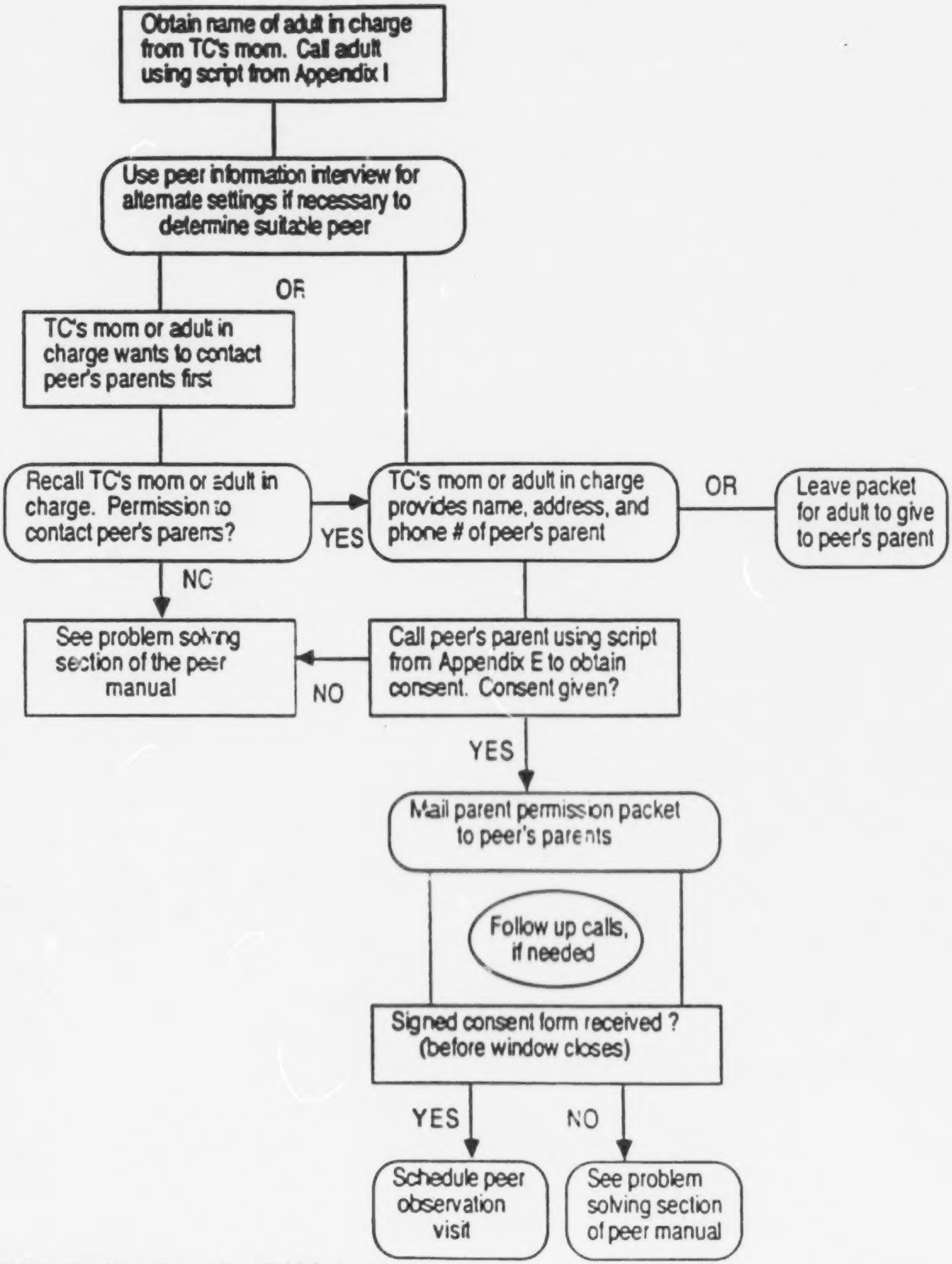
Follow up calls, if needed

Signed consent form received? (before window closes)

Schedule second Child care visit

See problem solving section of Peer Manual

FOURTH APPROACH TO OBTAINING PEER PARENTAL PERMISSION:


Obtain name of adult in charge from TC's mom. Call adult using script from Appendix I
Use peer information interview for alternate settings if necessary to determine suitable peer
OR
TC's mom or adult in charge wants to contact peer's parents first
Recall TC's mom or adult in charge. Permission to contact peer's parents?
YES
TC's mom or adult in charge provides name, address, and phone # of peer's parent
OR
Leave packet for adult to give to peer's parent
NO
See problem solving section of the peer manual
NO
Call peer's parent using script from Appendix E to obtain consent. Consent given?
YES
Mail parent permission packet to peer's parents
Follow up calls, if needed
Signed consent form received ? (before window closes)
YES
NO
Schedule peer observation visit
See problem solving section of peer manual

IV. PROBLEM SOLVING

Because of the variety of situations, settings and people involved with this procedure it is impossible to anticipate all the possible problems that will be encountered. Therefore, we have provided the following suggestions based on some of the problems that have been encountered during the piloting done at the Kansas site and at other sites. It is important to keep in mind that if there is a peer that meets the criteria available and it is possible to conduct the visit, then do the visit, trust your common sense. If you encounter an unusual situation that is not covered in the manual, discuss it with your project coordinator. If together you are unable to find a solution, send your question to Dr. Aletha Huston, 36-month chair, at the Kansas site and to the Data Coordinating Center and we will respond as soon as we can. If, after trying all possibilities a peer observation cannot be done, complete the Missing Peer Data Report Form and send to both the DCC and the Kansas site.

1. **During the 35-month phone call you learn that the child will be changing child care.**

Continue to Part 5-D and complete the Peer Grid. If there are peers available at the old primary childcare setting and you can conduct the peer observation before the child changes care, this would be the best approach. If there aren't any peers in the old primary child care setting or you don't have enough time before the study child's last day and there are peers at an alternate setting then conduct the peer observation at the alternate setting. If there aren't any peers available at an alternate setting, redo Part 5-D when you conduct the follow-up 35-month phone call. If there are peers available at the new setting, follow procedures for obtaining parental consent outlined in Part 3.

2. **During the 35-month phone call you learn that the study child will be starting a primary childcare setting.**

If the peer grid from Part 5-D of the 35-month phone call indicated that there is an available peer that meets the criteria in an established alternate setting then conduct the observation with this peer. If there are no peers available then redo Part 5-D when you conduct the follow-up 35-month phone call. If there are peers available at the new setting, follow procedures for obtaining parental consent outlined in Part 3.

3. **Study child's mother will not give permission to contact peers' parents.**

Try to ascertain what are her objections. It may be that she does not know the peers' parents well enough to provide their name, address and phone number to you. Reassure her that we can leave a packet of information about the study and the procedure with the provider/adult in charge to give to the parents. She may object to the choice of peer and prefers that the observation be conducted with a different peer. If the peer meets all of the criteria, then conduct the peer observation with this peer. If the mother objects to having the study child participate and you cannot assuage her fears, we have a missing observation. Complete the Missing Peer Data Report Form (DM-M) and send to the DCC.

4. **Peers' parents refuse consent or consent is not returned.**

If there are other peers that meet the criteria for observation in the primary setting, recontact the study child's mother, if necessary, to obtain name, address and phone number and contact peers' parents. If there are no other peers available, or their parents refuse, or their signed consents are not returned before 1 week has elapsed since the first childcare visit, then your fall back position is to conduct the observation with a peer in an alternate setting if available. See Section C of Part 3.

5. **At the time of the 35-month phone call the only available or first choice peer's age is either >28 but <30 months or >48 but <50.**

Try to schedule the observation so the peer's age will be between 30 to 48 months. If this is not possible and s/he is the only available peer, schedule as close as possible to the 30 or 48 month birthday and make note on the Peer Observation Videotaping Report form. If there is another peer available that meets the criteria, even if in an alternate setting, conduct the peer observation with this peer rather than the peer who is outside the age range for observation.

6. **Care provider at primary childcare setting refuses the childcare visits.**

She may be willing to allow you to conduct the peer observation. Describe how the procedure is short, usually one hour, and the study children and friends seem to enjoy playing in the portable playroom. If she is still unwilling, check the Peer

Grid for any peers available in any alternate settings, especially in any alternate childcare settings that you may now be observing.

Additions to the Problem Solving section will be made, as necessary, during piloting and training.

V. APPENDIX

A. SCRIPT FOR EXPLAINING PROCEDURE TO CHILD-CARE PROVIDER

"On our next visit, I will be bringing in a fan-folded piece of cardboard that will make a separate play area for STUDY CHILD and PEER. The playroom does take up some room. I will set it up wherever it is easiest and convenient for you. The children will play inside the playroom with three sets of toys for about 15 minutes. I will be videotaping their play.

"While I am taping STUDY CHILD AND PEER, it is best if the other children are occupied with another activity. The reason for this is to keep distractions to a minimum for STUDY CHILD AND PEER and help the other children feel they are also doing something special. (If you are calling ahead or having this conversation during the first child-care visit, you may offer to bring an activity, provided you are certain another person will be available to come to present that activity on the next visit. Otherwise, it is best to leave it up to the child-care provider. If you do offer to bring an activity, and your offer is accepted, be sure to find out the ages of the children who are expected to be present that day so you can choose a suitable activity.)

"I suggest that you let STUDY CHILD AND PEER know a few days ahead that they will be doing something special on the day we are coming. But it is important that they not expect the special activity to begin as soon as I arrive, because I will be observing your normal routine and activities for about an hour when I first come. After I finish observing, I'll bring the playroom inside.

"While I am setting up the playroom, it will help if you can explain to the other children that everyone who wants to can have a chance to play in the playroom, but STUDY CHILD AND PEER will be first.

"If STUDY CHILD and PEER are reluctant to enter the playroom, I may need you to go inside with them at first. This doesn't happen very often, and I will let you know if I need your help. Once the children begin playing, it is very important that you stay out of their sight and avoid talking to them if at all possible. This is because we want to see how the two children play together and how they work out sharing toys on their own.

"I will be watching the children play through the camera all the time, but I won't interrupt them unless they need help with something. If they have a conflict over the toys or begin to throw the toys, you may hear me ask them to play or to sit down. If they get very restless, we will move on to the next toy. If a situation comes up that I need help with, I will let you know.

"We want the children to play with each toy for a certain amount of time. When they're all through, [any of the other children who want to can play in the playhouse for a few minutes. I won't be able to videotape them, but they are welcome to explore the playroom if they like.] I'll have some stickers for all the children when we are done. How and when would you like me to give them out?" (Follow her suggestions when the time comes.)

B. SCRIPT FOR PRESENTING TOYS TO CHILDREN

Presenting Magnadoodle

"This is a Magnadoodle. These are the pieces that come with it. See?" SHOW THE CHILDREN THE PIECES. DEMONSTRATE HOW THEY WORK. MAKE A DEPARTING STATEMENT SUCH AS:

"Now you play with the Magnadoodle. I have some work to do, but I'll be back with another toy pretty soon."

LEAVE THE PLAYROOM, CLOSE THE CURTAIN, AND IMMEDIATELY START THE CAMERA AND YOUR TIMER.

SOME CHILDREN WILL TEST WHETHER YOU ARE THERE AND PAYING ATTENTION. TELL THEM BRIEFLY: "I have work to do. You play now."

DO NOT LOOK OVER THE WALLS OF THE PLAYROOM OR THROUGH THE CURTAIN

Changing toys

OPEN THE CURTAIN, TELL THE CHILDREN, "It's time to pick up the Magnadoodle and play with another toy,"

GO INTO THE PLAYROOM TAKING THE NEXT SET OF TOYS, BE SURE TO ENTER THE PLAYROOM COMPLETELY RATHER THAN TALKING THROUGH THE CURTAIN OR OVER THE PLAYROOM WALLS. PICK UP ALL THE PIECES AND PLACE THE MAGNADOODLE BEHIND YOU.

DO NOT PRAISE THE CHILDREN OR COMMENT ON THEIR PLAY.

Presenting the kitchen set.

"Here is a kitchen set. These are the pieces that come with it. Let me show you how it works."

RING THE BELL AND TURN THE KNOB TO MAKE THE BURNER RED.

Then say, "Now you play with the kitchen set." MAKE A DEPARTING STATEMENT SUCH AS: "I'll bring you another toy in a little while."

Changing toys

"It's time to pick up the kitchen set and play with another toy." GO INTO THE PLAYROOM TAKING THE NEXT SET OF TOYS, BE SURE TO ENTER THE PLAYROOM COMPLETELY RATHER THAN TALKING THROUGH THE CURTAIN OR OVER THE PLAYROOM WALLS. PUT ALL THE PIECES OF THE KITCHEN SET BACK INTO THE BAG AND PLACE IT BEHIND YOU.

AGAIN, DO NOT PRAISE THE CHILDREN OR COMMENT ON THEIR PLAY.

Presenting the flashlights

"I have some flashlights for you to play with. Let me show you how they work."

SHOW THE CHILDREN HOW THE SWITCH WORKS ON THE WORKING FLASHLIGHT.

HAND THE WORKING FLASHLIGHT TO THE STUDY CHILD

"You can play with these for a few minutes." MAKE A DEPARTING STATEMENT SUCH AS: "I have some more work to do."

IF CHILDREN COMPLAIN ABOUT ONE FLASHLIGHT NOT WORKING SAY "I'm sorry. I don't have any more flashlights. You'll have to play with those for a few minutes." (In some cases, you may need to repeat this a second time. After that, it is best to ignore the child's complaints or requests.)

Ending the session.

SAY SOMETHING FAIRLY NEUTRAL LIKE "We're all done, you really seemed to have fun in the playroom today." or "You really enjoyed these toys."

C. IDENTIFYING PEERS FOR OBSERVATION, FORM 35D

Part 5D: INTERVIEW TO DETERMINE THE AVAILABILITY OF PEERS

During this part of the call, you will use an interview along with the Peer Grid to obtain information about the other children with whom the study child plays on a regular basis, and determine whether any of them fit the criteria for peer play. Callers should be thoroughly familiar with the criteria for peers, as well as, with the format of the interview including its Check Points and skip patterns. Flow charts are included on Pages 41-44 to help you remember the various steps.

Check Point 1 - OBSERVABLE CARE: This is the starting point of the interview and by now you should know if the study child is in an observable primary child care arrangement and whether there are any other children in care. This information can be obtained from the completed Child Care Grid Form 10A. Keep it available during the interview as you may need to refer to it throughout. If the study child is in an observable child care arrangement and Question 30 on the Child Care Grid indicated that there are other children in the arrangement you will proceed to Question 1. If not, then you will go to Check Point 2 - OTHER REGULAR CARE.

Begin by briefly describing the peer observation to the mother, so she will have a general understanding of why we are inquiring about the availability of other children. Follow the script provided on page 1.

Question 1 and 6

This allows you the opportunity to **identify the setting** that you will be inquiring about and determine if it's okay with mother to conduct the peer observation.

Question 2a and 2b

If the study child's primary child care arrangement is in a Family Day Care Home then use Question 2a. Ask for the names and the ages of children who are the same gender as the study child and record the information on the Peer Grid in the section for the Primary Child Care to be Observed. If the study child's primary arrangement is in a center you will use Question 2b. This is because it is more likely that in center care there will be many children who are the same age as the study child and it is very unlikely that the mother will know all their names. Additionally, the names of the children that the mother does know will usually be the most familiar playmates of the study child. If there are more than 4 children list only 3 or 4 on the Peer Grid. If none of the children in the study child's primary child care arrangement are between 30 to 48 months and the same gender as the study child, you will go to Check Point 2. If the mother doesn't know the ages of the children then you will proceed to Question 5 and we will obtain that information from the child care provider.

Question 3, 8 and 13

This question is to help you determine which peer to observe if there are several boys or girls available between the ages of 30 to 48 months.

For each child that the mother names you will need to inquire about the nature of the children's friendship, the length of time acquainted, and how many hours each week they **regularly** play together. Again, keeping in mind the criteria for peers ask:

A: "How would you describe the children's friendship: best friends, close friends, just friends, acquaintances, or not friends?"

B: How long have the children known each other?"

C: How many hours a week are the children usually together?"

Questions 4, 9, and 14

The peer can **not be a sibling or live in the child's household** Other relatives, cousins for example, are allowed as long as they meet the criteria of not living in the study child's household.

Question 5

The purpose of this question is to find out if there are any other regular settings in which the study child plays with other children that may meet the criteria for peer observation. These may be another child care arrangement that we won't observe, a church based mother's day out program, a regular play group, or just an informal arrangement with a friend or neighbor. If the situation arises where it is impossible to observe peer play in the primary child care arrangement (the provider refuses, the peer's parent refuses etc.,) we will have the necessary information to determine if there is an alternate setting that may be observed and can expedite that process immediately. Record their first names and ages in months on the Peer Grid in the section for alternate arrangements, the nature of the friendship, the length of time acquainted, and how many hours each week they play together. Also ask the location where they usually play and the name of the adult in charge and record on the Peer Grid.

Check Point 2 - OTHER REGULAR CARE WITH OTHER CHILDREN PRESENT

You will begin Interview 5D at Check point 2. If: (a) if the study child will not be observed in care or (b) Question 30 of the Child Care Grid indicated that there were no other children in the primary child care arrangement or (c) that Question 2a or 2b indicated that none of those children are same sex as study child and between 30 and 48 months of age. If the Child Care Grid indicated that there is some regular child care that we won't be observing and that there are other children in this arrangement with the study child then you would proceed with Question 6. Only describe the peer observation to the mother if you did not do so earlier.

Question 7a and 7b

Same as 2a and 2b except that this will be for other regular arrangements. If none of the children in the arrangement are the same gender as the study child and between 30 and 48 months, you will go to Check Point 3 - ALTERNATE SETTING. If the mother doesn't know the ages of the children then you will proceed to Question 10 and we will obtain that information from the child care provider.

Question 10

Same as 5 except that this will be for other regular arrangements such as play groups.

Check Point 3 - ALTERNATE SETTING

You will begin Interview 5D at Check Point 3. If (a) the study child has no regular child care or (b) Question 30 of the Child Care Grid indicated that there were no other children in these arrangements or (c) question 2a, 2b, 7a and 7b indicated that none of the children are same sex as study child and between 30 and 48 months of age. Then you will proceed with Question 11.

Describe the peer observation only if you did not do so earlier.

Question 11 and 12

The purpose of these questions is to determine if there is any possibility of a peer in any alternate arrangement where we can complete the peer observation. A "no" response to either of these questions means that there will be no peer observation. Thank the mother for her help and tell her that we won't be able to do that part of the visit. Go on to part 6 of the 35-month phone call and schedule the home and playroom visit. If there may be potential peers at an alternate setting but the mother does not know the ages of the children then go to Question 4, of Part 5E.

SELECTION OF PEER

Use the Peer Criteria and the information from the mother that you have recorded on the Peer Grid to select two or more possible peers. If there are suitable peers then you proceed to Question 1 of Part 5E of the 35-month phone call and complete the Peer Information Worksheet for each peer. If there are no suitable peers for the observation in any setting then you'll need to tell the mother that we won't be able to do that part of the visit and provide an acceptable reason why. At this point some mothers may try to help by telling you the name of someone that the study child plays with or that she knows of a child who could come to play with the study child. Unless these children meet the criteria for peers, including the criterion of having known each other for at least 2 weeks, you must thank the mother and restate that we won't be able to do that part of the visit. Go on to part 6 of the 35-month phone call and schedule the home and playroom visit. If there may be potential peers but the mother has been unable to provide any key information necessary to identify peers then go to Question 4, of Part 5E. This information will be obtained from the child care provider at the end of the first visit or from the adult in charge of the alternate setting.

THE CRITERIA FOR PEERS:

a. In age range from 30 to 48 months

b. Same gender as study child

c. Has been acquainted with STUDY CHILD for 2+ weeks (preference given to children in the child care setting that we will be observing for the 36 month visit.); it is not preferable to observe the study child's "best" friend or a child who is not familiar to the study child.

d. Is not a sibling; does not live in same house as STUDY CHILD

e. Is not a subject in NICHD study unless no other peer is available

D. COMPLETING THE PEER INFORMATION WORKSHEET

FORM 35D, 35 MONTH PHONE CALL, PART 5E

Part 5E: COMPLETING THE PEER INFORMATION WORKSHEET

You will have obtained the first names of two or more peers during the interview process. For the first- and second-choice peers of those available you will need to obtain additional information so their parents can be contacted for their consent for the observation. Begin Part 5E: with Question 1, if a peer has been identified, or with Question 4, if the mother has been unable to provide any key information necessary to determine if the peer meets the criteria. Because of the wide range of situations likely to be encountered, it is important to be very familiar with the interview, as well as the suggestions in the Problem Solving section of the Peer Manual. The contact information should be obtained from the mother if at all possible. If the mother cannot provide contact information, first contact will be made through the child care provider or the adult in charge of the alternate arrangement. For more information on this process see Part III: ARRANGING PEER OBSERVATIONS in the Peer Manual.

You will use the Peer Information Worksheet to record all contact information the mother can give you about each peer. This worksheet will also be used to track the steps necessary in order to obtain consent for observation and will be retained at each site. In cases where peers' parents do not have telephones or they are unable to be reached after several attempts, a Parent Permission Packet (Appendix F of Peer Manual) can be sent out directly without the phone contact. In all cases, if the signed consent is not returned within a week, a follow-up call to the peer's parent must be made. If the peers' parents do not have telephones and the consent is not received within a week, begin the procedures for enlisting help from the child care provider (see Part III of Peer Manual).

More complete information regarding obtaining information about and contacting peers' parents is included in the Peer Manual.

E. PHONE CALL SCRIPT FOR PARENTS OF PEERS

PHONE CALL SCRIPT FOR INITIAL CONTACT WITH PARENTS OF PEERS

The following script is intended for use when contacting parents of potential peers for observation. It is important to have the completed Peer Grid and the Peer Information Worksheet in front of you, as you will be confirming the information regarding the peer that the study child's mother provided to the 35-month phone caller. If the information from the peer's parent contradicts that provided by the mother such that the peer does not meet the criteria, then we will NOT do the peer observation procedure with this peer.

BEGIN THE PHONE CALL

"Hello, I'm NAME from the NICHD Study of Early Child Care at the NAME OF SITE. Your name was given to us by NAME OF PARENT as being the parent of PEER is this correct?

IF NO APOLOGIZE FOR THE INCONVENIENCE AND CONTACT EITHER THE PARENTS OF THE SECOND PEER OR STUDY CHILD'S MOTHER AGAIN.

IF YES: "Currently we are conducting a study to learn about the variety of people, places and events that children experience in their early years. STUDY CHILD and his/her family have participated in interviews and observations since his/her birth.

"Now that STUDY CHILD is three years old, we would like to observe and videotape a play session between STUDY CHILD and a friend when they are at their (child-care provider's/center/play group). STUDY CHILD's mother mentioned that PEER also (attends/plays at) THE SETTING, is that correct?

IF NO TRY TO DETERMINE WHAT THE MISUNDERSTANDING IS. IF YOU DO ESTABLISH THAT THE CHILDREN DO PLAY TOGETHER, PROCEED WITH SCRIPT. IF NOT, APOLOGIZE AND CONTACT EITHER THE PARENTS OF THE SECOND PEER OR STUDY CHILD'S MOTHER AGAIN.

IF YES: "How many hours a week are the children together?" CHECK RESPONSE TO INFORMATION ON THE PEER GRID

"How long have the children known each other?" CHECK RESPONSE TO INFORMATION ON THE PEER GRID

"How old in months is PEER? CHECK RESPONSE TO INFORMATION ON THE PEER GRID TO DETERMINE IF PEER MEETS THE CRITERIA?

IF NO APOLOGIZE AND GIVE AN REASONABLE EXPLANATION FOR WHY WE CAN'T DO THE VIDEOTAPE WITH PEER AND THEN CONTACT EITHER THE PARENTS OF THE SECOND PEER OR STUDY CHILD'S MOTHER AGAIN

IF YES THEN PROCEED "We would like to know if it would be okay with you to observe and videotape PEER and STUDY CHILD while they are at THE SETTING. Does this sound like something you would be interested in?

IF NO: LISTEN TO THE PARENT'S CONCERNS AND TRY TO ADDRESS THEM. TRY TO EXPLAIN THE OBSERVATION PROCEDURES AND THE CONFIDENTIALITY OF THE VISIT.

IF YES: "Great! Let me tell you a little bit about the procedure. We will be taking in a portable play area for STUDY CHILD and PEER. The children will play inside the playroom with three sets of toys for about 15 minutes and we will videotape their play. We have found that most children really enjoy the playroom. Do you have any questions?

IF YES: TRY TO ANSWER THEM. THEN GO ON WITH SCRIPT

IF NO: "We will be mailing you a letter with a little more information about the project, a consent form for you to sign and a self addressed stamped envelope for you to return the consent form to us within the week if possible. Could I have your address?

IF NO SAY YOU UNDERSTAND AND TELL PARENT YOU WILL LEAVE THE CONSENT FORM WITH THE CARE PROVIDER DURING YOUR FIRST VISIT.

IF YES OBTAIN ADDRESS AND WRITE IT ON THE PEER INFORMATION WORKSHEET

"Thank you very much for your help. You will be receiving the letter shortly, and please remember to complete and sign the consent form and return it to us as soon as you can. If you have any questions, please call us at PHONE NUMBER; this telephone number will be included in the letter as well. Thank you for your help."

BE SURE TO MAIL THE PERMISSION PACKET IMMEDIATELY

F. PEER PARENT PACKET

1. INFORMATIONAL LETTER FOR PEER'S PARENTS WHO WERE NOT INITIALLY CONTACTED BY TELEPHONE

Dear Parent,

Your child's name, PEER was given to us by STUDY CHILD'S PARENT'S NAME as being a playmate of STUDY CHILD. We at NAME OF SITE are conducting the NICHD Study of Early Child Care, a national study designed to learn about the variety of people, places and events that children experience in their early years. STUDY CHILD and his/her family have participated in interviews and observations since his/her birth.

Now that STUDY CHILD is three years old, we would like to observe and videotape a play session between STUDY CHILD and a friend when they are at SETTING. We would like to request your permission to observe and videotape PEER and STUDY CHILD while they are at THE SETTING. STUDY CHILD's parent/mother has already given us permission to do so, provided that you also agree.

The procedure consists of taking into THE SETTING a portable playroom for STUDY CHILD and PEER. The children will play inside the playroom with three sets of toys for about 15 minutes. We will be videotaping their play. We have found that most children really enjoy the playroom.

If you would like to have PEER participate, please complete and sign the consent form and return it by mail to us in the enclosed self- addressed stamped envelope within the week if possible.

If you have any questions please feel free to call PROJECT COORDINATOR'S NAME, Project Coordinator at NAME OF SITE at PHONE NUMBER.

Thank you very much in advance for your interest and assistance with this important study.

Project or Team Coordinator

2. INFORMATIONAL LETTER FOR PEER'S PARENTS WHO WERE CONTACTED BY TELEPHONE

Dear Parent,

As per our telephone conversation of DATE, your child's name, PEER was given to us by STUDY CHILD's PARENT as being a playmate of STUDY CHILD. We at NAME OF SITE are conducting the NICHD Study of Early Child Care, a national study designed to learn about the variety of people, places and events that children experience in their early years. STUDY CHILD and his/her family have participated in interviews and observations since his/her birth.

As we mentioned on the phone, now that STUDY CHILD is three years old, we would like to observe and videotape a play session between STUDY CHILD and PEER when they are at their (child-care provider's/center/play group/setting). We would like to request your permission to observe and videotape PEER and STUDY CHILD while they are at THE SETTING. STUDY CHILD's parent/mother has already given us permission to do so provided that you also agree.

The procedure consists of taking into THE SETTING a portable play area for STUDY CHILD and PEER. The children will play inside the playroom with three sets of toys for about 15 minutes. We will be videotaping their play. We have found that most children really enjoy the playroom.

Please complete and sign the following consent form and return it by mail to us in the enclosed self-addressed stamped envelope within the week if possible.

If you have any questions please feel free to call PROJECT COORDINATOR'S NAME, Project Coordinator at NAME OF SITE at PHONE NUMBER.

Thank you very much for your interest and assistance with this important study.

Project or Team Coordinator

3. INFORMATIONAL LETTER FOR PEER'S PARENTS BEING CONTACTED THROUGH CARE PROVIDER OR ADULT IN CHARGE OF AN ALTERNATE SETTING

Dear Parent,

We at NAME OF SITE are conducting the NICHD Study of Early Child Care, a national study designed to learn about the variety of people, places and events that children experience in their early years. STUDY CHILD and his/her family have participated in interviews and observations since his/her birth.

Now that STUDY CHILD is three years old, we would like to observe and videotape a play session between him/her and a friend when they are at SETTING. The procedure consists of setting up a portable playroom for STUDY CHILD and a friend. The children will play inside the playroom with three sets of toys for about 15 minutes. We will be videotaping their play. We have found that most children really enjoy the playroom.

With your permission your child may be chosen to be videotaped while playing with STUDY CHILD in our portable playroom at THE SETTING. STUDY CHILD's parent/mother has already given us permission to observe and videotape her child.

If you are willing to allow your child to participate, please complete and sign the following consent form and please return it to CARE PROVIDER/ADULT IN CHARGE within the week.

If you have any questions please feel free to call PROJECT COORDINATOR'S NAME, Project Coordinator at NAME OF SITE at PHONE NUMBER.

Thank you very much in advance for your interest and assistance with this important study.

Project or Team Coordinator

PLEASE PRINT ON LETTERHEAD

CONSENT TO PARTICIPATE IN THE PLAY SESSION

CHILD ID

I give permission for my child to participate in the NICHD Study of Early Child Care and to be videotaped for a fifteen minute play session with a friend in the portable playroom. I authorize the NICHD Study of Early Child Care to obtain information about my child's attendance at this setting, and to observe and code my child's play from the videotape.

____
Parent's name

______________________________ ______________________________
Child's name Parent's signature

Date:_________________________

Child's Birthdate:____________

Sex: M F

Birth Order ___

Race or Ethnicity:
_____ Native American
_____ Black or Afro-American
_____ White _____ Asian
_____ Biracial _____ Other
_____ Don't know

Is child of Hispanic origin? Y N

Length of time in present child-care arrangement: ________ months

Number of hours per week in child-care arrangement: ________ hours

Please return to:
_____ Your childcare provider

_____ The study in the enclosed envelope

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G. PEER INFORMATION INTERVIEW FOR CHILD-CARE PROVIDER

PEER INFORMATION INTERVIEW FOR CHILD CARE PROVIDER

(FOR SITE USE – DO NOT RETURN TO THE DCC)

STUDY CHILD'S NAME ________________ STUDY CHILD ID# ____________

USE THIS AFTER YOU HAVE EXPLAINED THE PROCEDURE USING SCRIPT A.
ASK ONLY ABOUT CHILDREN OF THE SAME GENDER AS STUDY CHILD.

"I have a few questions to ask you about some of the other children in your care."

1a.	Earlier, you said there were (NUMBER RECORDED ON YOUR ORCE CYCLE) (boys/girls) between the ages of 30 and 48 months.	☐ CONFIRM
	OR	
1b.	Do you care for any (boys/girls) between the ages of 30 and 48 months?	☐ Y ☐ N GO TO page 2
	GET AT LEAST TWO NAMES IF POSSIBLE FOR EACH CHILD NAMED, RECORD FIRST NAME, AGE, AND ASK QUESTIONS AS NECESSARY TO COMPLETE THE GRID:	☐ RECORD
2a.	How would you describe the children's friendship with STUDY CHILD?	☐ Best Friends ☐ Close Friends ☐ Just Friends ☐ Just Acquaintances ☐ Not Friends
2b.	How long have the children known each other?	____________
2c.	How many hours a week are the children usually together?	____________
3)	Are any of these children siblings of STUDY CHILD or live in the same household with STUDY CHILD?	☐ Y ☐ N

PRIMARY CC SETTING TO BE OBSERVED

Playmate's first name	Age in months	Gender (Male/ Female)	Friendship: Close, Best, Just, Acquaintance, Not-Friends	How long have they known each other?	Hours per week together?	Sibling/Same Household (YES/NO)
		M F	B C J A N			Y N
		M F	B C J A N			Y N
		M F	B C J A N			Y N
		M F	B C J A N			Y N

TRY TO IDENTIFY 2 PEERS WHO FIT THE CRITERIA:

a. In age range from 30 to 48 months
b. Same gender as study child
c. Has been acquainted with STUDY CHILD for 2+ weeks (preference given to children in the child care setting that we will be observing for the 36 month visit); not preferable to use study child's "best" friend
d. Is not a sibling; does not live in same house as STUDY CHILD
e. Is not a subject in NICHD study unless no other peer is available

IF NO POSSIBLE PEERS:

"It doesn't look like any of the other children (are the same age/ have been acquainted long enough, etc.), so we won't be able to do that part of the visit next time, but let's go ahead and schedule our next visit."

CHECK PEER GRID FROM 35-MONTH PHONE CALL FOR POTENTIAL PEERS IN ANY ALTERNATIVE SETTING. IF YES, FOLLOW PROCEDURES OUTLINED IN SECTION C OF PART III OF PEER MANUAL.

IF POSSIBLE PEERS HAVE BEEN IDENTIFIED:

"It looks like PEER(S) would work out. I'll leave with you (two/one) packet containing a brief description of what the children will do, the phone number of the study in case PEER/S parents have any questions, as well as a consent form for them to sign and return to you or to mail to the study which ever you think would work out best. I'll call back in a few days after the permission slip/s have been returned to schedule our next visit. Thank you, we greatly appreciate your help."

BE SURE TO CHECK THE APPROPRIATE BOX AT THE BOTTOM OF THE CONSENT AND LEAVE A STAMPED SELF-ADDRESSED ENVELOPE IF THE PROVIDER WANTED THE PARENTS TO MAIL THEM TO THE SITE.

H. TELEPHONE SCRIPT FOR ALTERNATE SETTING

The following script is intended for use when contacting the director, parent or adult in charge of the alternate setting.

"Hello, I'm NAME from the NICHD Study of Early Child Care at the NAME OF SITE. Your name was given to us by STUDY CHILD'S PARENT'S NAME as being the (director/parent/coordinator) of (name of program/child) where STUDY CHILD and PEER play each week, is this correct?

IF NO: PROBE TO FIND OUT WHY CHILD IS NOT THERE. IF PEER IS NO LONGER AT THE SETTING, TRY TO IDENTIFY ANOTHER POTENTIAL PEER IN SETTING USING THE PEER INFORMATION INTERVIEW FOUND IN APPENDIX I. IF THERE IS NOT A PEER AVAILABLE, THANK HIM/HER FOR HER TIME AND SAY GOOD- BYE. IF YOU DETERMINE THE AVAILABILITY OF ANOTHER PEER THEN CONTINUE.

IF YES: Currently we are conducting a study to learn about the variety of people, places and events that children experience in their early years. STUDY CHILD and his/her family have participated in interviews and observations since his/her birth.

Now that STUDY CHILD is three years old, we would like to observe and videotape a play session between STUDY CHILD and PEER.

USE A.) IF YOU HAVE VERBAL CONSENT FOR PEER'S PARENT
USE B.) IF YOU WILL BE CONTACTING PEER THROUGH ADULT IN CHARGE OF THE SETTING

A.) We have contacted PEER'S PARENT and they have agreed to let his/her child participate.
B.) We can leave a packet of information about the study with you to give to PEER's parent to see if they would like their child to participate.

We would like to know if it would be possible to do the observation while these two children are in your care. Does this sound like something you would be interested in?

IF NO: LISTEN TO THE CHILD-CARE PROVIDER'S CONCERNS AND TRY TO ADDRESS THEM. TRY TO EXPLAIN THE OBSERVATION PROCEDURES AND THE CONFIDENTIALITY OF THE VISIT. AS WELL AS THE FACT THAT THEY WILL BE PAID FOR THE VISIT.

IF YES: Let me tell you a little bit about the procedure. We will be bringing in a fan-folded piece of cardboard that will make a separate play area for STUDY CHILD AND PEER. The playroom does take up some room. We will set it up wherever it is easiest and convenient for you. The children will play inside the playroom with three sets of toys for about 15 minutes. We will be videotaping their play. We have found that most children really enjoy the playroom. Do you have any questions?

IF YES: Try to answer them.

IF NO: IF YOU ALREADY HAVE SIGNED PARENTAL CONSENT THEN SCHEDULE A TIME TO VISIT WHEN BOTH CHILDREN ARE THERE AND IT IS CONVENIENT FOR CAREGIVER. KEEP IN MIND THAT THE WHOLE PROCEDURE TAKES ABOUT 40-45 MINUTES INCLUDING SETUP AND TAKE DOWN. IDENTIFY CHILD-CARE MEMBER WHO WILL BE VISITING AND LET THE CAREGIVER KNOW THAT THEY WILL PROVIDE MORE INFORMATION AT THE TIME OF THE VISIT.

IF YOU ARE CONTACTING THE PEER'S PARENTS THROUGH THE ADULT IN CHARGE OF THE SETTING MAKE ARRANGEMENTS TO DROP-OFF THE PARENTS PACKETS AND A TIME FOR A FOLLOW UP CALL.

THANK THEM FOR THEIR HELP AND RECONFIRM TIME AND LOCATION. Good-bye."

I. PEER INFORMATION INTERVIEW FOR ALTERNATE SETTINGS

PEER INFORMATION INTERVIEW FOR ALTERNATE SETTINGS
(FOR SITE USE – DO NOT RETURN TO THE DCC)

STUDY CHILD'S NAME ________________ STUDY CHILD ID# ____________

USE THIS AFTER YOU HAVE EXPLAINED THE PROCEDURE USING SCRIPT H.

"I have a few questions to ask you about some of the (girls/boys) in your care."

1. Are any of the (girls/boys) that STUDY CHILD plays with between the ages of 30 and 48 months?
☐ Y
☐ N GO TO page 2

(GET AT LEAST TWO NAMES IF POSSIBLE)
FOR EACH CHILD NAMED, RECORD FIRST NAME, AGE, AND ASK QUESTIONS AS NECESSARY TO COMPLETE THE GRID:
☐ RECORD

2a. How would you describe the children's friendship with STUDY CHILD?
☐ Best Friends
☐ Close Friends
☐ Just Friends
☐ Just Acquaintances
☐ Not Friends

2b. How long have the children known each other? ____________

2c. How many hours a week are the children usually together? ____________

3. Are any of these children siblings of STUDY CHILD or live in the same household with STUDY CHILD?
☐ Y
☐ N

PRIMARY CC SETTING TO BE OBSERVED

Playmate's first name	Age in months	Gender (Male/Female)	Friendship: Best, Close, Just, Acquaintance, Not-Friends	How long have they known each other?	Hours per week together?	Sibling/Same Household (YES/NO)
		M F	B C J A N			Y N
		M F	B C J A N			Y N
		M F	B C J A N			Y N
		M F	B C J A N			Y N

TRY TO IDENTIFY 2 PEERS WHO FIT THE CRITERIA:

a. In age range from 30 to 48 months
b. Same gender as study child
c. Has been acquainted with STUDY CHILD for 2+ weeks (preference given to children in the child care setting that we will be observing for the 36 month visit); not preferable to use study child's "best" friend or a child not familiar to STUDY CHILD.
d. Is not a sibling; does not live in same house as STUDY CHILD
e. Is not a subject in NICHD study unless no other peer is available

IF NO POSSIBLE PEERS:

"I'm sorry but it doesn't look like any of the other children (are the same age/ have been acquainted long enough, etc.), so we won't be able to do the visit. I appreciate your time and help with answering my questions. Thank you.

NO PEER OBSERVATION WILL BE DONE

IF POSSIBLE PEERS HAVE BEEN IDENTIFIED:

"It looks like PEER(S) would work out. I'll leave with you (two/one) packet containing a brief description of what the children will do, the phone number of the study in case PEER/S parents have any questions, as well as a consent form for them to sign and return to you or to mail to the study which ever you think would work out best. I'll call back in a few days after the permission slip/s have been returned to schedule our the visit. Thank you, we greatly appreciate your help."

BE SURE TO CHECK THE APPROPRIATE BOX AT THE BOTTOM OF THE CONSENT AND LEAVE A STAMPED SELF-ADDRESSED ENVELOPE IF THE PROVIDER WANTED THE PARENTS TO MAIL THEM TO THE SITE.

J. PEER OBSERVATION VIDEOTAPING REPORT, FORM 36P
PEER OBSERVATION VIDEO SHIPPING LIST, FORM 36V

PEER OBSERVATION VIDEOTAPING REPORT

DATE

Month		Day		Year
				199
0	0	0	0	3
1	1	1	1	4
	2	2	2	
	3	3	3	
	4		4	
	5		5	
	6		6	
	7		7	
	8		8	
	9		9	

INTERVIEWER ID

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

ID NUMBER

0	0	0	0	0	0
1	1	1	1	1	1
2	2	2	2	2	2
3	3	3	3	3	3
4	4	4	4	4	4
5	5	5	5	5	5
6	6	6	6	6	6
7	7	7	7	7	7
8	8	8	8	8	8
9	9	9	9	9	9

INFORMATION FOR QUESTIONS 1, 2 AND 3 SHOULD BE OBTAINED FROM THE PEER'S PARENT CONSENT FORM:

1a. Peer's birthdate?

Month		Day		Year	
0	0	0	0		0
1	1	1	1		1
2	2	2	2		2
3	3	3	3		3
4	4	4	4		4
5	5	5	5		5
6	6	6	6		6
7	7	7	7		7
8	8	8	8	8	8
9	9	9	9	9	9

1b. Number of peer's older siblings?

0
1
2
3
4
5
6
7
8
9

2. Peer's sex

1 Male
2 Female

3. What is his/her race or ethnic group?
If Other Specify: ____________________

A) RACE OR ETHNIC GROUP
1 American Indian, Eskimo, Aleut
2 Asian or Pacific Islander
3 Black or Afro-American
4 White
5 Other (Specify)
6 Biracial
7 Don't Know

B) OF HISPANIC ORIGIN (INCLUDES CHICANO/A LATINO/A)
0 No
1 Yes

ASK THESE QUESTIONS OF PERSON IN CHARGE OF THE ARRANGEMENT (READ QUESTION 4-7 AS WRITTEN)

4.	How would you describe the children's friendship? (READ RESPONSES)	1 Best friends 2 Close friends 3 Just friends 4 Acquaintances 5 Not friends
5.	How much time do STUDY CHILD and PEER usually spend together per week?	____ hours 0 0 1 1 2 2 3 3 4 4 5 5 6 6
6.	How long have CHILD and PEER known each other?	☐ 2 weeks-1 month ____ months 0 0 1 1 2 2 3 3 4 4 5 6 7 8 9
7.	Did any of the following things happen that would make today different from a typical day? (CHECK ALL THAT APPLY)	
	STUDY CHILD was sick	☐ yes
	PEER was sick	☐ yes
	PEER'S behavior was different	☐ yes
	STUDY CHILD'S behavior was different	☐ yes
	Any other unusual circumstances ____________________ ____________________	☐ yes
	Who answered questions 4-7?	REL CODE __ 0 mother 1 father 2 grandparent 3 other relative 4 primary child-care provider 5 support child-care provider 6 child-care provider 7 director

COMPLETE REST OF REPORT AFTER TAPING

8a. **Was observation conducted at the study child's observed Primary Child-care setting?** ☐ yes ☐ no

IF YES:

8b. Setting ID

0	0	0	0	0	0	0
1	1	1	1	1	1	1
2	2	2	2	2	2	2
3	3	3	3	3	3	3
4	4	4	4	4	4	4
5	5	5	5	5	5	5
6	6	6	6	6	6	6
7	7	7	7	7	7	7
8	8	8	8	8	8	8
9	9	9	9	9	9	9

IF NO

c. Where?

1 Another regular child care setting
2 Group play setting
3 Peer's Home
4 Study Child's Home
5 Another Home
6 Laboratory Playroom
7 Other ____________________

9. TIME TAPING BEGAN
(use 24-hour clock)

0	0	0	0
1	1	1	1
2	2	2	2
	3	3	3
	4	4	4
	5	5	5
	6		6
	7		7
	8		8
	9		9

TIME TAPING ENDED
(use 24-hour clock)

0	0	0	0
1	1	1	1
2	2	2	2
	3	3	3
	4	4	4
	5	5	5
	6		6
	7		7
	8		8
	9		9

10. Where there interruptions? ☐ yes ☐ no

a. Reason ____________________________

Length of interruption
____ min.

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

b. Reason ____________________________

Length of interruption
_____ min.

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

11. Was procedure terminated? ☐ yes ☐ no

12. Which toys were terminated? (mark all that apply)
☐ Magnadoodle
☐ Kitchen
☐ Flashlights

Reason ____________________
____

13. Identifying information for STUDY CHILD (describe clothing, appearance, hair color, etc.)
____
____
____

PEER OBSERVATION VIDEO SHIPPING LIST

TO: MARION O'BRIEN

FROM: ________________, SITE

DATE: ________________

ENCLOSED ARE PEER OBSERVATION VIDEOS FOR THE FOLLOWING FAMILIES:

ID____________________	DATE____________________
ID____________________	DATE____________________
ID____________________	DATE____________________
ID____________________	DATE____________________
ID____________________	DATE____________________
ID____________________	DATE____________________
ID____________________	DATE____________________
ID____________________	DATE____________________
ID____________________	DATE____________________
ID____________________	DATE____________________
ID____________________	DATE____________________
ID____________________	DATE____________________
ID____________________	DATE____________________
ID____________________	DATE____________________
ID____________________	DATE____________________
ID____________________	DATE____________________
ID____________________	DATE____________________

COMMENTS: ____

The NICHD Study of Early Child Care Form 36V Revision 11/11/93

CHAPTER 28

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The Bracken Submanual (Section 2) was created by Kathleen McCartney. Responsibility for the Interview and Questionnaire Submanual (Section 3) was taken by Marsha Weinraub and her committee of Martha Cox, Aletha Huston, Nancy Marshall, and Marion O'Brien. Responsibility for creating the HOME Submanual (Section 4) was taken by Bob Bradley and Judith Brisby, working from the Fifteen Month Submanual for the HOME created by Bob Bradley working from material supplied by Margaret Tresch Owen and Bettye Caldwell. Responsibility for producing the Operations Manual and coordinating the submanuals was taken by Bob Bradley and Aletha Huston, Chair of the 36-month subcommittee.

CHAPTER 28

Section 1

OPERATIONS MANUAL THIRTY-SIX MONTH HOME VISIT

I. OVERVIEW OF THIS MANUAL

This manual provides specific information necessary for conducting the 36-month home visit. The components of Section I are: Parts II and III contain general information about the visit; Part IV contains specific information about setting up and managing the course of the visit; Part V contains instructions for activities to be completed after the visit to the home; Part VI contains instructions for unusual circumstances; Part VII includes safety guidelines for making home visits; and Part VIII contains general information on training for the visit. Section 2 contains specific instructions for administering the Bracken. Section 3 contains specific instructions for conducting the HOME. Section 4 contains the specific instructions for conducting the 36-month interview and for administering the questionnaires. The outline of procedures is illustrated in Figure 28.1.

Figure 28.1

At the Home Visit

1. Warm-up and initial observation for H.O.M.E. (15 minutes)
2. Administration of the Bracken with child while mother completes Questionnaire Set I (15 minutes)
3. H.O.M.E. interview (45 minutes)
4. Standardized Interview Section I and II and Questionnaire Set II (35 minutes)
5. Check over Questionnaires and finish Questionnaire Log
6. Ear Infection Data Collection
7. Address/Phone Number updates
8. Post-Visit Interview with Mother
9. Debriefing
10. Payment
11. Preparation for the Next Contact

After Completion of Visit:

12. Complete Post-Visit Rating on Mother and Child (Form 15R)
13. Complete Interview Report Form (DM-D)
14. Complete Home Visit Report Form (Form 39X)

II. GENERAL CONSIDERATIONS FOR THE THIRTY-SIX MONTH HOME VISIT

A. Your Role as a Visitor

As a home visitor, your main objective is to obtain accurate, reliable information in the most pleasant way possible. Home visitors must balance their professional role and objectives with their role of being a friendly, respectful guest in someone's home. Many unexpected things arise in the home that require flexibility on the part of the visitor. Your flexibility conveys your respect for the person and the way she does things in her home. Your flexibility and openness, however, should in no way compromise your professional agenda. The tone of the home visit is that of a friendly, relaxed yet professional visit.

There are several ways that you can prepare yourself for this role. First, become totally familiar with the protocol. This familiarity will make you comfortable enough to be flexible and also will help keep your professional agenda in mind as you accommodate to the unique circumstances facing you. Second, become familiar with thirty-six-month-olds and the kinds of issues mothers are concerned with for children at age 3. Third, dress the part: wear casual, yet professional clothes. Fourth, maintain awareness of situations that arise which prevent you from feeling totally comfortable with your role. Discuss these with your PI or site coordinator. Determine whether there is a better way to deal with such situations in the future.

B. About thirty-six-month-olds

It is important to be comfortable with 36-month-olds and knowledgeable about their ways. Thirty-six-month olds do not act like the infants and toddlers seen during the earlier home visits. Most are quite mobile and have surprisingly good communication skills. Most have also begun to demonstrate some self care routines. They no longer need parents to do everything for them, but they are still quite dependent on adults for managing many of their affairs. It is not uncommon for three-year olds to assert their independence and to make choices (sometimes quite stubbornly) about things they like and dislike. They are alternately full of wonder and full of themselves. Throughout this manual, we will try to refer to a three-year-old as a child. Three-year-olds generally do not like to be called "babies".

Reading about three-year-olds is a good idea. Site Directors often can recommend good reading material; there are several child development textbooks that provide useful information. Here we present a few crucial points, especially for those Visitors less familiar with 3 year old children.

As soon as you see the child, notice and comment on something positive about this child to the mother. Not saying anything is sometimes taken as a slight; honestly saying something nice is usually easy to do. Be careful not to overdo it or to say anything judgmental that could be taken as negative

-- even an innocent comment can stay on the mother's mind for a long time.

Say hello to the child, but do not push the child to respond to you. Wait for the child to warm up to you. Three-year-olds generally do not exhibit the kind of "stranger anxiety" associated with children closer to one year of age. However, this does not mean that some will not be wary or intimidated by your presence. Some are simply shy. When you feel the child is comfortable with you, speak to the child or respond to the child's overture in a gentle way. Usually it is helpful to speak to the child at the child's eye level. For this you may need to squat or to get down on the floor. You may find it helpful to spend time around some 3 year olds in order to become more familiar with children this age.

It is also helpful to review the place of the 36-month visit within the context of the full study. Families' lives are changing. Many more mothers will be back at work. The children are past the unsettled first couple of years. They are quite mobile, can often communicate quite well, and are in the process of exploring the world on their own, testing limits, and in some cases, patience. The youngsters are interacting more and more with others, and they will be more curious about you and your equipment than ever before. The children may be involved in numerous exchanges with siblings. Some will have at least one younger sibling by now. By the time of our 36 month visit, the study is nearly over. Most mothers will be quite used to seeing

RAs from your site and may well consider you as a part of their "extended" family.

C. The Key to a Successful Visit

As much as possible, the 36-Month Home Visit should be pleasant and satisfying for the family. In this regard, it is helpful for you to see this as a friendly visit. The Visitor must be as relaxed as possible and try to help the mother feel relaxed as well. On first entering the home, spend a few minutes just chatting. "How have you been?" may be reasonable to ask, or you may discuss any other topic of common interest (the weather). Making positive comments about the house, children, pets are all things that make people feel more relaxed and positive toward you. In other words, be a polite, friendly visitor to the home, showing you are interested in the family as people as well as in the information they can provide.

Show interest and positive attention to the mother. Look at the mother as she answers your questions. Don't just look down for where to record the answer. Be careful, however, to avoid using terms such as "That's fine", "Good", or "Okay" after the mother completes an answer. Even seemingly innocuous statements after the mother says something may subtly reinforce particular types of answers.

In either the HOME or the Interview, if the mother elaborates on something when you really only need a brief answer, say something polite like, "Yes, I see what you mean, I think I've got what I need here." If she goes on and on and it's becoming a problem, say "You're giving me a lot of information, but I'm afraid I'll take up too much of your time, so I'll try to let you know when I've got enough so we can move on." Then, let her know that you have enough information and that you need to go to the next question. Remember that you don't want people to feel cut off, but that people may become irritated if your visit lasts longer than you promised (even if the cause is due to the mother's desire to give you more than you've requested of her).

In striving to keep the visit pleasant and friendly try not to let the visit become tedious by allowing it to take longer than you promised. This should be handled delicately. While we do not wish to dwell on problems or concerns or get distracted by digressions, interviews should be handled with sensitivity. Sensing indifference could lead the mother to treat our needs for information with suspicion or indifference in turn.

D. Sharing Personal Information

Avoid sharing personal information (e.g. what child care experiences you have had). By sharing such information, you may inadvertently establish certain response biases in the mother as she assesses what your value may be. The reliability and validity of the data depend upon the Visitor being able to establish an interpersonally neutral atmosphere. Making evaluative statements after the mother answers a particular question, making evaluative comments on behaviors observed in either mother or toddler or sharing personal information with her are major ways that a Visitor can introduce bias into the data collected. The visitor is better advised to ask the mother what she thinks than to express the visitor's own opinion.

E. Expressing Appreciation

Be sure to emphasize at some point during the visit the importance of the mother's contribution to the research, how worthwhile and important the research is, and how much the mother's time is appreciated. This is often a good thing to do as you are leaving, if it hasn't come up before. Say something like, "We really appreciate your time. This research is important to understanding how early experiences affect how children develop, so we appreciate that you have spent so much time and effort helping with this project."

F. When the Visitor Observes Family Difficulties

A difficult and serious problem arises when something is revealed at the home visit which suggests that the child (or mother) is in "jeopardy". To understand what constitutes jeopardy, each 36 month home Visitor should review Principle 9 of the "SRCD, Standards for Research with Children", which is included in Chapter 6.1, Appendix H of the NICHD Study of Early Child Care manuals. Prior to conducting any home visits, the Visitor should also become familiar with indicators of child abuse and the laws governing reporting this to the authorities in your state. You should immediately report to your PI what you saw or that you have suspicions of abuse despite hard evidence.

Your site should have prepared information on laws and procedures applicable in your state for the One Month Home Visit. Before beginning the 36 month assessments, it would be useful for your site to check on whether there have been any changes to the laws in your state over the last few years. A list of indicators and definitions of child abuse, prepared by the Wisconsin site, is included in Chapter 6.1, Appendix A.

G. Obtaining Consent

The original consent forms for the NICHD Study of Early Child Care did not mention home visits for the 36 month assessment period. Because consent for this visit was not obtained, it will be necessary to have the mothers sign another informed consent before the 36 month home visit. Each site will be responsible for developing its own consent form. This consent form should cover only procedures, both common protocol and site specific, that are relevant to the 36 month assessment. This form must be signed before the 36 month home visit can be started.

In addition, an initial consent form for the follow-up study will be obtained on a separate form. Normally this consent is presented during the lab visit. However, there will be times when the home visit will follow the lab visit. In an effort to see that the present study is completed before permission is requested for the follow-up study, it is necessary to present the consent form at the last visit -- which is usually the lab visit but may, on occasion be the home visit. Thus, request for participation in the follow-up study should be presented for signing after all portions of the 36 month assessment are completed, regardless of which comes last. Chapter 29.1 contains details for the follow-up study recruitment and consent procedures.

III. THE VISITOR

A. Task distribution

Only one Visitor will collect data for the 36-month home visit. No videotaping is planned for the visit, and mothers can usually arrange things so that the 36-month old does not require special management by a second visitor. None the less, if other children will be at home, it is advisable to send a second visitor for child minding. Study Coordinators should generally be aware of any special provisions that need to be made in the case of particular families. If more than one RA goes on a visit, one RA should be designated as "the Visitor". That person is responsible for administering all procedures for the visit, making sure the visit flows smoothly, reviewing forms, and completing the post-visit information.

B. Who Can be Home Visitors

The RA designated as home Visitor for any given family should be different from the RA who observes the same family's child in child care at 36 months. The home Visitor may see the family in the laboratory visit. Home visitors may or may not have conducted earlier home visits. If, however, the Home Visitor is very familiar with a family's maternal employment or child care history from previous home, lab or child care visits or from conducting tri-monthly update calls, they should not conduct the home visit with the family if at all possible. In addition, it is expected that sites will try to design staffing patterns such that 35 month callers are not collecting data at the 36 month assessments. Sites will make reasonable efforts to maintain the blindness of observers, as detailed in this manual. However, it is recognized that particular staffing patterns and issues of subject rapport will necessitate modifying these procedures in some instances. After each visit, Visitors will complete Form 39X, indicating what information they had about the family before testing the child. If 36-month home visit cannot be completed in a single contact in the home, the same visitor should conduct the follow-up visit, unless the Bracken still needs to be completed and the Visitor is no longer blind to child care and/or maternal employment information.

IV. CONDUCTING THE THIRTY-SIX MONTH HOME VISIT

A. Age Window for Data Collection

The 36-month home visit will be scheduled to occur from the child's 36 month birthday to the day before the child's 38-month birthday. For example if the child's birthday is August 15, the scheduling window will be August 15 to October 14. Every effort should be made to complete data collection within this window.

B. Exception Period

If the visit cannot be completed during the window, you may complete it at a later date, up to but not including the child's 41-month birthday. Data collected on or after the child's 38-month birthday should be flagged as collected during the "exception period" by completing and sending an "Exception Period Data Collection Form" along with the data to the Data Coordinating Center.

Although it is preferable for the home visit to precede the child care and lab visits, this may not always be possible. Do not cancel a lab or child care visit if the home visit is not complete (e.g. if it was canceled).

C. Equipment Needed for Visit

Carry all forms and materials arranged in order in a container. Bring additional copies of the forms, in case anything happens to this set or the father is present and wants to look them over or complete them. You will need the following:

1. Face sheet with mother's full name, address and phone number, in case you need to contact her on your way.
2. The HOME
3. The Bracken kit
4. The Interview and Questionnaire forms
5. Map
6. Directions
7. Writing board
8. Several #2 pencils
9. Extra interview and questionnaire forms
10. The response cards
11. The Questionnaire Log
12. Ear Infection Forms
13. The Interviewer Report Form
14. The Observation Report Form
15. Some large self-addressed stamped envelopes in case the mother needs to mail some forms (see Unusual Circumstances section).
16. Tape recorder (audio) and Microphones, if reliability of Bracken and Interview are to be checked
17. An envelope to put completed data in
18. Subject payment and a receipt book for subject payments or forms to sign for obtaining payment (method of payment determined by sites)

19. The Home Visit manual
20. The set of toys if young siblings will be present
21. Postcards to notify lab as address changes occur
22. Directions for the mother to get to the laboratory and maps, if necessary, or information about how to arrange transportation to the lab
23. Information for the mother about parking at the lab
24. A card for the mother with the date of her lab visit and the telephone number of the lab

A checklist for common protocol materials appears on the face sheet of the interview form. Each site may also want to develop a checklist which includes both common protocol and site-specific materials so that Visitors can easily prepare for each home visit.

D. Pre-Visit Preparation

A 35-month phone call (between 34.5 and 35.0 months) will have been conducted that gathers child care data and schedules the 36-month home and lab visits. For the 36 month Home Visit, it is extremely important to take steps to ensure that Visitors will be blind to maternal employment and child care information before they administer the Bracken. Thus, the 35 month call and any additional scheduling calls must be made by someone other than the Visitor who will be seeing this family.

One to two days before the scheduled visit the mother should be re-contacted to verify the time and date of the visit.

If the mother does not have a phone, she should be re-contacted in what ever manner has been previously arranged so that she receives a reminder within two days of the visit. If visits are scheduled more than two weeks in advance, mothers may have difficulty remembering their appointments with us. Sites may want to send the mothers reminder postcards 7 days prior to the scheduled visit. Because employment information is often revealed during a confirmation call, it will also be necessary to have Home Visitors confirm each other's visits. Finally, remind mothers at the confirmation call to not discuss their employment or child care status with the Visitor until she is specifically asked about this information.

If you feel that you may be contagious with any illness, reschedule or find a substitute. Even if you think that you are not contagious, mothers will not appreciate your coughing and sneezing in their home.

Before going to the home there are at least two things to do to prepare for the visit. First, the primary visitor should check a map to make sure that the directions received from the mother are correct. Checking the map will also help the Visitor plan the time she needs to find the mother's home and to anticipate delays. Second, the Visitor should check that all equipment is functioning properly, and all necessary supplies, materials and equipment are packed and ready to go.

E. Sequence of Procedures During Visit

1. Ideal order

The ideal order of administration or completion of forms is as follows:

a. Warm-up.

b. Administration of the Bracken with child while mother completes Questionnaire Set I.

c. H.O.M.E.

d. Standardized Interview Sections I and II and Questionnaire Set II.

e. Check over Questionnaires and finish Questionnaire Log.

f. Ear Infection Data Collection

g. Address/Phone Number Updates

h. Post-Visit Interview with Mother

i. Debriefing

j. Payment

k. Preparation for Next Contacts/Departure

This order should be followed whenever possible. If you alter the sequence of assessments from the planned order, note this on the Home Visit Report (39X) and send it to the Data Center.

2. When the order can be changed

The order of administering measurement procedures for the 36-Month Home Visit outlined above is an "ideal" order. So long as conditions permit, this order should be followed. Adhering to a standard order of administration should help to minimize within-site and across-site variability. Having a standard order also tends to help Visitors avoid "mix-ups" and missing data and to move the Visit along smoothly and expeditiously. However, things can happen during the course of a visit that make it appropriate to change the order of administration.

Despite attempts to schedule the visit when the child is awake, it is possible that the child will be asleep when you arrive. If that is the case, you may begin the visit by administering Section I of the Standardized Interview. If the child is still not awake, then proceed by administering Questionnaire Set I to the mother. (Section I of the interview and Questionnaire Set I will not reveal employment or child care information to the observer). If the child is still not awake, proceed with Interview Section 2 and Questionnaire Set II, if necessary. You will then need to note on Form 39X that you were no longer blind to maternal employment information before administering the Bracken. If after completing the Standardized Interview and Questionnaires the child is still not awake, you may want to reschedule the rest of the visit. If rescheduling is necessary and you have not yet completed the Bracken (or H.O.M.E.), it may be advisable to return with another Visitor blind to maternal employment and child care information who could administer the Bracken.

If the child awakens during the administration of the Interview or Questionnaires, these procedures should be interrupted and resumed later in the visit. Once the child is awake and alert, the Visitor should proceed with the 15 minute Warm-up period during which initial observations for the H.O.M.E. are completed. As soon as the child awakens, the Visitor should tell the mother that this seems like a good time to take a break. The Visitor can also explain to the mother that it would be helpful to give the child some time to wake up and get familiar with the Visitor. During this warm-up period, the Visitor should not make any specific attempts to direct any of the mother's or child's activities. Be responsive but not directive. You may fill some of this time by discussing things with the mother such as those listed under F.1. "Warm-up period" in this chapter. If the mother wants to continue filling out questionnaires, that is fine so long as the child is present and you do not prevent any interaction between the mother and child. You may also make friendly overtures towards the child so that she or he will feel comfortable with you before beginning the Bracken. Because you will move from this warm-up period right into administering the Bracken, you can also use this time to describe to the mother the order of procedures to follow next.

After this initial warm-up period, proceed with the Bracken. If the mother has not completed both sets of questionnaires at this point, give her a set to complete during the Bracken. Next, you will complete the H.O.M.E. Once the H.O.M.E. is completed, resume with the Interview and Questionnaire procedures at whatever point they had to be interrupted previously.

Other circumstances may also necessitate changing the order of procedures. When rearranging the order of presentation, you must bear in mind the minimum requirements for administering each of the home visit procedures. The guiding principle to follow is that the child must be awake and alert for at least one hour of observation for the H.O.M.E. (this includes the 15 minute warm-up period and the 45 minute H.O.M.E. interview period) and must be awake and alert for the Bracken. The Bracken should if at all possible be completed before the interview portion of the H.O.M.E. The order of the administration of the Interview and Questionnaires is flexible and may be adapted to the particular circumstances of the home visit. As much as is possible, adapt the procedures so that the administration of the Bracken remains blind.

Two principles should predominate in the decision to adjust the order of presentation. Principle #1 - the minimum conditions necessary for obtaining valid information from each given measurement procedure must be maintained. If a child must be alert and attentive, a mother free from distractions, the room quiet enough so that the Visitors words are clearly heard, etc., then it is essential that these conditions be present. If that means changing the order, then change the order. Principle #2 -- every effort should be made to make the Visit as comfortable as possible for the family. Not only does this honor our commitment to high ethical standards in conducting the study, but it will help insure both the ecological validity of the data and participant continuation in the study. By the time of the 36-month Home Visit, most families will clearly understand our needs to maintain standardization in data collections (they have become pretty "robust", too). But, some children may need more of mother's attention during the Bracken (or Mom may just be "real interested"), some Moms may need to be more involved in management of sibs during the Bracken, or some Moms may need more assistance in doing the Questionnaires: whatever the reason, if circumstances clearly seem to dictate that the order of administration be changed, change it. It is essential that these two principles not be used as license to change the order of administering procedures. Be conservative. Change only when change is really necessary to insure validity and to maintain rapport.

F. Arrival

1. Establishing initial rapport

Upon arrival at the mother's home, offer a friendly greeting to her and to anyone else present. Ask how everything is going, etc. For example,

> "Hello Mrs. SURNAME, I'm VISITOR's NAME from the Early Child Care Study at YOUR SITE (and this is VISITOR TWO'S NAME--if a child minder visitor is also sent). It's nice to see you again (if previously seen). I appreciate your letting me (us) come and visit you today. How has everything been going for you and CHILD?..."

After your initial greeting, also gently remind the mother to not discuss her employment or child care situation with you until you ask about it. The child is likely to be present. Try to say something nice to the mother about the child. Greet the child by name, but do not try to approach CHILD physically or pursue conversation if CHILD seems shy or wary or you. If and when CHILD makes overtures to you, respond with quiet, friendly remarks.

2. Warm-Up period and initial H.O.M.E. observation

Since the H.O.M.E. will not be administered first, as it was during the 15 month home visit, it is important to allow sufficient time at the beginning of the visit for the mother and child to relax and become acquainted with you. Otherwise, the child may not be "ready" to perform comfortably and attentively on the Bracken. Continue to talk with the mother and engage the child in a relaxed and friendly manner. Chat about common place things, current events or things that have happened recently in the community. Avoid asking about personal things, anything that might lead to a discussion of child care arrangements or things the child had been learning since the responses may lead to prejudicial actions on your part. The following is a list of questions you might ask:

Questions to mother

a. *"What did your family do this weekend?"*

b. *"Did you see _____ on TV last night?"*

c. *"Are you a football(baseball, basketball, etc.) fan?" "Did you see the game?"*

d. *"Where did you get CHILD's pretty dress (cute pants, shoes, hair ribbon, etc.)?"*

e. *"I haven't seen CHILD for a year and I can't believe he has grown so much. You must keep busy keeping him in clothes. He must not be a fussy eater. What are his favorite foods?"*

f. *"I was just noticing the cross-stitch pictures on the wall. Did you do them? How long did it take to do the one with the street scene?"*

Questions to child

g. *"That looks like a fun toy. How do you work it? How so you use it? Where did you get it?"*

h. *"Your mother said you went to the fair last night. Did you ride any rides? Did you see any animals? What animals did you see?"*

i. *"Since there is a new baby in your house, you are now a big brother. Does that make you feel proud? What do you do to help your mother with the baby?"*

During this warm-up period, you will also begin making initial observations for the H.O.M.E. You will not, however, be asking any direct questions relevant to the H.O.M.E. items. This warm-up period must last at least 15 minutes so that you have the requisite time to make the H.O.M.E. observations. If the mother appears eager to begin the visit, explain to the mother that you would like some time to allow the child to get comfortable with you before you begin the Bracken. You can also use this time to give the mother an overview of the visit and by finding and setting up a place for the Bracken.

3. Giving an overview of the visit

After introductions, convey something like the following script to give mother an overview of the visit:

"As (give the 35 mo. phone caller's name) told you, this visit will be similar in some ways to the one we made when CHILD was 15 months old. It will probably last about 2 hours. First, we will have CHILD show us some things [he/she] knows and can do. I'll give you more specific details about what we'd like for that part a little later. During that time, I'd like you to fill out some questionnaires. Then, I'll ask you some questions about CHILD's experiences and activities. Following this, I'd like to ask you some of the same questions about your family's health, your employment, and CHILD's activities that we've asked in earlier interviews. Then I'll ask you to fill out some more questionnaires similar to those you filled out last time."

(If there are site specific tasks, describe these here as well.)

"If you think CHILD is going to be OK for awhile and not need to nap or eat soon, then I'd like to get started first by having CHILD show us the things [he/she] knows first. While CHILD is doing this, I'd like you to fill out these questionnaires. They are similar to those you've filled out before." If the child is sleeping when you arrive or the mother indicates the child is quite sleepy, you can say instead, "If you think CHILD is likely to fall asleep soon or need to take a nap we can rearrange the order of things. We can work through all of the interviewing and questionnaires first and hope [he/she] wakes up.)"

When mothers or other household members ask for more detail about the study or about the questions we are trying to answer, rephrase the information in the consent form or consult the information at the end of the Two-Week Telephone Interview. If people press for more information than you have, or if they ask for information which may prejudice the mother about the purpose of the study, tell them that you are not sure what the answer is at this time, and that you'd like to check with the Director of the Project and get back to her. Never say "I don't think I'm supposed to tell you that," or "I'm not sure if I can tell you that." Families have the right to be fully informed.

If you can't answer all of their questions, let them know that you will promptly get back to them with an answer.

Mothers have already had 4 home visits similar to the one at thirty-six months, so they may pretty much have our routine down. Nevertheless, you are in charge and you will want to execute the visit smoothly.

4. Getting down to business

Next, ask the mother where would be the most comfortable place to talk with her. Ask the mother if she is expecting anyone to come over in the next couple of hours. Sometimes mothers will have someone drop by. If you know this will happen, you may be able to minimize its disruptiveness.

Anticipate that phone calls may cause interruptions. Ask the mother how she would like to handle things if the phone should ring. Ask the mother if she would mind letting the answering machine (if it appears likely that one might be in the house), or if she would mind letting the father (if appropriate), get the call. If neither one applies, ask if the second visitor (if present) can answer the phone.

5. Handling the presence of the father, other adults, and children (other than target child)

There will be cases in which the mother's partner or some other adult will be at the home when you arrive. Tactfully tell the other adult [he/she] does not have to remain present through the first parts of the visit. If the other adult does not take the hint or really wants to observe the interview, be gracious. Try to handle the situation with good humor. Do not convey to the other adult that [he/she] is not welcome.

If the father remains present during the HOME you will need to tell the father again that you must ask the questions directly to the mother even if they involve him. For example, you might want to say, "We often don't have the benefit of having fathers present during our visits, so the interview has been designed for the mother to answer all questions, even those directly dealing with you. To be consistent, I must get all of the responses from your wife/partner. You may, however, want to let me know if we are missing something." Repeat this as often as it is appropriate. If the father does give you information, be sure to record the mother's response unless the father interjects more accurate information about objective questions pertaining to him (e.g., occupational title). Never, however, ask any questions directly of him.

If the father is not a participant in the study, he may look over the questionnaires if he wishes. Be sure to thank him for his interest in the study.

If father is a participant in the study, follow the HHS group protocol in dealing with his presence.

If other siblings are present, follow mother's lead during the HOME interview (i.e., they can be present or not, at mother's discretion). However, siblings should be occupied elsewhere during the Bracken and the Interview and Questionnaires.

G. Audiotaping the Interview for Reliability

If this interview is to be audiotaped for reliability purposes, ask the mother if she minds having her interview taped. The researcher may want to say something like, "We often need to tape our interviews to make sure that all of our researchers are following the same procedures. Only researchers on the project have access to these tapes. Would you mind if we taped today's interview?" In most cases, the mother will not mind, but it is polite to ask before beginning the interview. If the mother objects to the taping, be gracious and make sure that the next interview conducted by this interviewer is taped (unless the next mother objects, of course.) (See Section 4 the Interview and Questionnaires Submanual for specific instructions).

H. Exiting

1. Post Visit Interview - Form 15Q

Question in the Post Visit Interview are designed to be open ended. Do not read response choices to the mother. Instead, let her answer in her own words, then code the information she gives you. Questions 8 and 9 should only be asked of mothers who are employed or in school. We are interested in finding out the day and time the mother last arrived home from work or school, and the day and time she will be leaving the house to go to work or school again. The purpose of these items is to determine when home visits are occurring relative to mother and child separations. We are concerned that an imminent separation or a recent reunion in the lives of employed (in school) mothers may affect results. Work in the home or at the office while the child is present does not count for these questions.

2. Debriefing

It is important at the end of the visit to "debrief" the mother. Ask the mother if there is anything we didn't ask about that she thinks is relevant. Ask if she has any comments or questions about the visit she would like to share with us. The Visitor needs to be sensitive to any negative feelings in the mother and needs to give the mother a chance to share her feelings. If the mother asks questions about the research hypotheses, try paraphrasing the information for the families in the consent form and two-week phone call. This is necessary to give the mother a sense that she is an important part of the research process, to give her the chance to tell us if the visit captured out-of-ordinary circumstances, and to express any adverse feelings she may have about the visit.

3. Paying the mother

Thank the mother for all her time and help. Explain how important this study is, and how we value her time and help. Pay her $35.00, or make arrangements to pay her (See Unusual Circumstances for payment procedures when visits are not completed).

4. Preparing for the next contacts

If the mother has not yet had her 36-month lab visit, the most important order of business here is to confirm the time and date of that visit and go over with the mother information about how to get to the lab and, if appropriate, where to park. Written directions as to how to get to the lab or how to arrange for transportation may be necessary at some sites. Remind the mother to call if she cannot come at the scheduled time. Tell her that someone will call a day or two before the visit. If the mother tells you that the scheduled lab time is no longer convenient, either reschedule her on the spot, tell her that someone from the lab will call to reschedule, or call your office to let her speak with a scheduler.

Mothers may want to know what will happen at the lab. You may tell her something like: We will videotape CHILD playing with toys, we will do some measures of language and play styles, and we'll videotape you and CHILD playing together. We'll ask you to fill out some questionnaires and to answer some questions. You will be in a different room than CHILD part of the time, but you will be near-by and you may return to CHILD whenever you like.

Mothers may want to know if they will have to leave their children as they did at the 15 month lab visit, or what's the purpose of having mother and child in different rooms for a while. If they ask questions in this vein it is important to communicate that the mother should not coach the child ahead of time about the details of what is going to happen in the playroom. Tailor the following response to the mother's particular concern.

> *"There are several reasons why you and CHILD are in separate rooms for part of the visit. We are interested in variations in the early development of self-reliance, so for some of this time we want to see how CHILD behaves*

when you are nearby but not in the same room. Because self-reliance is one of the areas in which we are interested, we ask you not to tell CHILD ahead of time that you and child will be separated for part of the playroom visit. We prefer that you simply explain that you and CHILD will be going to the playroom at (SITE), as you did when CHILD was younger, and that there will be lots of different things to see and do there."

Leave the mother a business card or some small information card with your name on it that she can file or "put on the refrigerator." If the lab visit is scheduled, be sure to have the date and time of the lab visit on the card. If the lab visit is to be rescheduled, cross out the original date on the card. Say, *"We'll be in touch with you, but if anything changes for you or if you want to contact us, please call. Our number, and my name, is on this card."*

If the mother has already had her lab visit follow the procedures for Recruitment for Phase II in manual Chapter 30.

I. Departure

Leave the mother with a good feeling about your visit. As you leave, give the mother positive feedback along the lines of. "You've really been helpful to us," "I've enjoyed meeting you and working with you." "You really have a beautiful child." "We still need to add the videotape section of the 36-month lab visit to your family's tape. As soon as your family's tape is ready we will send it to you." If the study is extended beyond the current age 3 termination point - you may want to add, "I'll look forward to visiting you again."

V. POST-VISIT ACTIVITIES

A. Checking the Data

After the visit is completed, the primary visitor should look over the entire Interview form and Questionnaires, the Bracken form, and the HOME form to make sure each item was completed and coded properly. It is also recommended that the Interview be double checked by another 36-month home Visitor.

B. Documentation of the Visit

To document the visit, the Visitor will need to complete some forms after leaving the home.

1. Questionnaire Log - 290

Complete the Questionnaire log sheet during the home visit to be sure all Questionnaires are complete. **This form is kept at the site.**

2. Interviewer's Report Form - DM-D

The Interviewer's Report Form gives the visitor(s) a place to record in more detail any extenuating circumstances that may have affected the 36 Month Protocol, report the presence of unusual or maladaptive behaviors of the mother or child, and describe the mother's comments following the Interview. It also affords an opportunity to record any comments the Visitor wants to make about the home visit. This form is filed in the subject's personal file at the site.

3. Post Observation Ratings Checklist - 15R

Complete the Post Home Visit Rating of Mother and Child Behavior. It is used to rate the Visitors' impressions of the entire visit, including an overall impression of the mother-child relationship. Questions 2-4 dealing with videotaping are not answered at 36 months. This form is returned to the Data Coordinating Center.

4. Home Visit Report (Form 39X)

Complete Form 39X and mail a copy along with the data to the Data Coordinating Center.

5. Log Book

We also recommend that each site keep an informal log book on each visit. Here you could include information about who the Visitors met during the visit, general comments about the proceedings, and note some non-protocol information about the visit such as things the Visitor discussed with the mother, the name of the family dog, etc. This information may be useful in maintaining rapport if there are contacts beyond the planned 36-month visit. Be careful not to include information that may bias future Visitors; only information that may help them respond as sensitive, friendly visitors to the family -- if the study is not extended beyond age three, this latter caution may be a moot point.

C. Posting the Data

See Chapter 3, "Data Management and Paper Forms Handling" for information on posting the data forms to the Data Coordinating Center.

D. Maintaining Rapport

Each site will send some type of thank-you note to the families after both the home and lab visits are completed. Each site can decide the form of the note with which they feel most comfortable. All sites will send the children yearly birthday cards. Each site can also decide whether they want to send holiday cards.

VI. ENCOUNTERING UNUSUAL CIRCUMSTANCES

Listed below are some situations that may be encountered on the 36-month visit and our suggested solutions. We realize that each site is different and may need to have special procedures.

1. The Visitor arrives and the mother is not home.

If possible, leave a note saying you were there. Include a copy of your card with a request that she call the office. Put these in an envelope. Before leaving the area, attempt to call the mother from a nearby phone booth to make sure that she really is not home (e.g., her doorbell may not be working). If the mother is not home, the Visitor or the scheduler should attempt to contact the mother as soon as possible. Every attempt should be made to reschedule the visit soon.

2. The mother refuses to participate once the visitor arrives at the home.

If at all possible, the Visitor should try to determine exactly why the mother refuses to participate before leaving the home. By keeping accurate records of refusals and drop-outs, we may have some insight into the biases that may creep into our sample. If the refusal is related to specific circumstances of the day or week, then arrangements to reschedule the visit or re-contact her should be made. Do not pay her. Thank the mother for her earlier participation and leave. The P.I. or Study Coordinator should follow up on this situation.

3. The Visitor arrives at the home and the mother says that she or the child is not feeling well and she wants to reschedule.

The Visitor should try to determine why the mother did not phone the office to cancel her appointment. Was it a sudden illness that prevented the mother from contacting us? The Visitor should offer to reschedule if the mother or child was truly ill and the mother was too busy or too distracted to call us. If possible, she should be rescheduled on the spot. However, it may be that neither the mother nor her child is ill; the mother just does not want to be in the study anymore. The Visitor should verbally check this out with the mother. If the mother does not want to be rescheduled, the Visitor should thank the mother and politely leave. Tell your PC or PI of the circumstances when you return to the lab/office. The mother will be called and rescheduled if possible.

4. The house you are visiting is chaotic, noisy, etc. There does not seem to be a place to do a quiet interview or a videotape session without many interruptions.

This should occur infrequently because strong efforts to minimize disruptions should occur during the scheduling of the visit. However, if the situation arises and the mother seems very eager and cooperative, we should ask her if there is a better time to reschedule the visit if there is absolutely no way to get through the visit. You may decide that since this is a longitudinal study, it is best to collect these data under less than optimal conditions in order not to lose the opportunity to see this family at this data collection point.

Almost any interview can be gotten through despite interruptions. It is best to plan ahead for these interruptions by leaving ample time in the Visitor's schedule to complete the visit. It is also the case that earlier visits were completed with this family, making it probable that a 36-month visit will be manageable with perseverance, thoughtfulness and sensitivity.

5. The mother is very hostile, uncooperative, high, etc.

If the mother is merely uncooperative or somewhat hostile, the visitors may want to switch gears and allow the mother to do more open-ended talking for a while. If this does not help, reassure the mother that her participation is strictly voluntary and that if she finds the questions or procedures in any way a problem, she can withdraw at any time with no penalty. If the mother is being uncooperative by refusing to answer any questions, reassure her that all information is held in the strictest confidence. Keep in mind, however, that it is the mother's free choice whether or not to answer particular questions.

If the mother is overtly high or psychotic, the Visitor should leave the house as soon as possible, as tactfully as possible. The Visitor can skip through the protocol to go to the end and ask a few final questions. If the mother asks why the questions are being skipped, she can be told they are not applicable to her situation. Data from the 36-Month Home Visit will be missing in this case.

6. What if the mother wants to change the order of the questionnaires she completes?

The Visitor should tell the mother we need to keep things standardized and that we need to keep the forms in their original order. If she is resistant, allow her to complete the forms her way. Indicate on the protocol that the order was changed and how.

7. What if we/she has to leave before finishing the protocol? A return visit will need to be scheduled if:

a. The HOME INVENTORY could not be completed (see specific contingencies in section 28.2).

b. The Bracken could not be completed.

c. At least half of the Interview could not be completed. It may be possible to do it in the lab visit. If not a return visit to the home will be needed.

8. What if the mother asks to fill out the written sections at another time and offers to mail them in?

You may leave the questionnaires and a self-addressed stamped envelope for the mother to mail back or bring with her to the lab visit. Ask her to complete the forms by herself in the order they are given to her. Stress that you will need to receive the forms within the week. Tell her that you will mail or deliver the payment for the visit after you receive the questionnaires. Say something like, "The final thing we do in these visits is to pay you. As soon as I get all the questionnaires, I'll see that you get your payment for the visit." Call to remind her if you have not received them back within four days. If you have not received the forms within the week, call again to remind the mother. If you get the sense from this second phone call that there is some trouble in filling out the questionnaires, try to schedule a time to return to the home and help the mother work through them. If there are also a few remaining interview questions, schedule a time to call the mother to complete these questions over the phone. This call should be made within the next working day, if possible.

9. What if the visitor(s) sees indicators of child abuse, potential abuse or evidence the mother or child is in jeopardy?"

Prior to conducting any home visits, the Visitor should become familiar with indicators of child abuse and the laws governing reporting abuse to state authorities. You should immediately report to the PI any instance of abuse or suspicions of abuse. A list of indicators and definitions of child abuse, prepared by the Wisconsin site, is included in Appendix A of Chapter 6. See also Principle 9 of SRCD Ethical Standards for Research with Children.

Any suspicions of abuse or other dangers should be reported to the PI immediately. If required by state laws, this information should to be reported to the appropriate authorities. If the family still wants to be in the study, they should still be included.

10. If the mother and her child are not living together in the same household at the time of the 36-month visit, what do we do?

If the father, legal guardian, or another person who has been taking care of the child has agreed to participate at the 35 month phone call, schedule all visits. Do not drop the original family at this point. See the instructions in the Alternate Caregiver interview to be used with respondents other than the mother.

11. What if the mother's partner is female? Do we ask all partner questions in relation to this person?

If the mother defines a woman as her partner, then all questions pertaining to partners in the 36 Month Structured Interview (not the H.O.M.E.) should be asked with respect to this person. The Interviewer should substitute "she" for "he" wherever appropriate.

12. What if the mother cannot, or does not want us to visit her at home?

Arrange to visit her in another setting or in a second lab visit. If the mother is living in someone else's home or in a shelter, you may visit her there. Complete the Bracken and the interview and questionnaires. However, the HOME should not be completed, as it might give an inaccurate impression of the "usual" environment of the child and mother. If you cannot arrange an alternative place for the visit, arrange to send the mother the questionnaires, and to interview her on the phone.

13. What if the target child or sibling(s) persists in distracting the mother or vying for the mother's attention?

If siblings are to be present during the visit, it is a good idea to bring a child minder. The home visitor should be able to distract siblings and prevent them from interrupting the interview. A visitor may also be able to reduce interference by bringing extra toys for the target child and siblings to play with.

14. What if the Mother Reveals Personal Problems?

Occasionally, in a mother's eagerness to talk, she makes an implied or direct appeal for help with her own personal problems. The Visitor should be careful about trying to handle these problems or solve them for the mother. The Visitor might say something like "I can understand your being upset (or concerned) about that. When we finish with the things we have to do, maybe we can talk about it more."

Each site has developed its own resource list to meet the needs of their families on a case-by-case basis. We will not routinely give mothers any information concerning resources. This may constitute an intervention. For example, if the list contained information about "Fun Things to Do With Your Kids," we may be subtly encouraging mothers to behave in certain ways with their children. If the mother requests such information, however, we do have a responsibility to provide information about available resources.

Researchers at each site should be relatively familiar with the services that are available to parents in their area. If a situation arises wherein a mother requests information or some type of referral, the researcher may say something like, "I can see that you would like help. I am not (trained) (in a position) to help you, but perhaps you would like me to talk with Dr.---, our Director, and he/she will know of someone who could be of help to you." If mother says yes, ask "Would you like for her/him to call you?" Immediately after the visit is completed, write the mother's concerns and requests on the Interviewer Report Form (see Interview and Questionnaires Sub-Manual, Section 28.4) and discuss the situation with your Study Coordinator and/or Principal Investigator. One of you should get back to the mother as promptly as possible with the appropriate information.

Each site should keep a record of the kind of information distributed to a particular parent and what impact, if any, this had on the family's life, if known. (This can also be recorded on the Interviewer Report Form.)

VII. SAFETY GUIDELINES

Occasionally, home visitors will have to go to an area with which they are unfamiliar. In some cases, they may have to make the decision not to collect the home data at 36 months because the family's home is unsafe to visit. It is, therefore, essential that visitors be able to evaluate the safety of an area and learn how to increase their safety when traveling in unknown areas. We have compiled two lists to help visitors with these tasks. These indicators are only imprecise guidelines. The presence of these indicators does not necessarily mean that the area is unsafe, nor does the absence of these indicators necessarily mean that the area is safe. These are meant only as indicators to consider. Sometimes visitors will have to go on their 'gut reaction'. Remember -- the safety of home visitors is paramount! Never enter or stay in a situation where you feel threatened.

A. Things to consider in evaluating the safety of an area.

There are three significant characteristics of dangerous areas: isolation, evidence of drug use or criminal activity, and a general air of abandonment. Remember that these characteristics do not always indicate danger, but they are signs that should be attended to. Some indicators of dangerous areas include:

Isolation

Poorly lit areas

People walking around with no apparent destination

Closed down industrial or business establishments

Nobody to go to if there is a problem (i.e., areas with boarded up homes, closed businesses or industrial firms)

Evidence of drug use or criminal activity

Lots of graffiti

Adults and teenagers loitering on street corners during the day

Prostitutes standing around on corners

Empty liquor bottles Crack vials and syringes on the street

House with lots of people going in and out

Abandoned or boarded up buildings

Unkempt homes: Broken windows, homes in need of extensive repair

Area with many boarded up homes

Many old or abandoned cars

More trash than normal

The appearance of any one of the above characteristics does not mean that an area is unsafe. However, if you notice several of these characteristics, and you have a gut feeling that you should not be in that area, it probably means that the area is unsafe.

B. How to Increase Your Safety

1. Dress casually, in flat shoes, with no jewelry. (A casual watch is fine.)
2. Do not go into a possibly unsafe area alone.
3. Have exact directions to the home. Tell the mother that you are unfamiliar with the area and ask her exactly where to park the car.
4. Arrive early in a neighborhood to check things out. If you give yourself plenty of time then you will be better able to make an evaluation of the area.
5. Carry minimal equipment in a canvas tote.
6. Don't carry a purse.
7. Don't leave anything in your car. If your car has a trunk, try not to keep the equipment in there. If you are seen going into the trunk, someone may suspect that you have other things in the trunk.
8. Look like you know where you are and what you are doing. If you look intimidated, you are more likely to be the target of crime.

9. Make sure that someone knows the time of your visit and the time that you are expected to return.

10. Keep in contact with the local police precinct. They can answer many questions you may have about an unfamiliar area.

C. Dealing with unusual circumstances from a safety perspective

1) If the visitors arrive in front of the house and decide it is too dangerous to get out of the car, or the house looks "too questionable to enter", the visitors should get to the nearest safe phone booth and call the mother to tell her that they are not coming. In cases where the visitors know that they are going to a borderline neighborhood, they should arrive early to check out the situation. This way they will also minimally inconvenience the mother because they will call her about the time they should have been arriving rather than leaving her waiting. In this case, it may be better not to tell her the truth about our fears of her house and neighborhood because this may be inaccurate and unkind. Visitors could tell her that something happened and they couldn't get to her house.

For the 1-month home visit, the decision was made not to reschedule when the situation was too dangerous. We will attempt to handle these circumstances differently at 36 months, since this is a longitudinal study. We now have considerable data and time invested in each family. If possible, reschedule the visit and enlist help from security or police personnel to enable you to make the visit on the next try.

If you know from previous visits a home is in a dangerous neighborhood, you should check out the area at least 48 hours before a scheduled home visit as was done before the 1 month visit. If you see that the neighborhood does not at this time meet the criteria for "safe," make arrangements to have the help of security or police personnel to get from your car to the home and back. If you cannot obtain help to make the visit safely, then cancel the appointment and attempt to collect as much Interview and Questionnaire data as possible over the phone, through the mails, or in a second lab visit. Upon receipt, send the mother a check for $35.

2) If the Visitor enters the house and decides the situation looks unsafe: the Visitor should leave the Questionnaires and arrange to visit the mother at another time. For the next visit, Visitors will need to arrange security or police protection. [Upon receiving the questionnaires, send a check for $35.]

If the visitor enters a situation which appears okay at first but later becomes dangerous, she should leave as soon as she can and as tactfully as possible without compromising her personal safety. As she leaves, she can briefly explain that this looks like a bad time. As above, leave Questionnaires and arrange for a phone Interview. Pay the mother upon receipt of questionnaires.

If the visitor decides not to see a family because of concern about safety, or leaves before the visit is completed, she should report it to the Study Coordinator and Principal Investigator. In addition, the visitor should document why and how she arrived at the decision to terminate the home visit so that a written justification, based on each site's guidelines, can be sent to the Data Coordinating Center. (See the Safety Exclusion Form, in Appendix D of Chapter 6.1.) Some suggestions on developing site-specific safety guidelines are contained in Appendix G of Chapter 6.1.

In sum, in those cases where danger or other circumstances prevent the making of a 36-month home visit, the following procedures for collecting data normally obtained in the home should be followed:

a) The interview should be done by phone.

b) The Bracken should be given at the end of the 36-month lab visit.

c) The Questionnaires should be mailed to families prior to the lab visit. Families should be asked to bring completed Questionnaires to the lab visit.

d) If the Bracken can not be managed during the normally scheduled lab visit, a second lab visit should be scheduled for purposes of completing the Bracken. If a second lab visit is scheduled, the Questionnaires should also be done at this visit.

e) The HOME cannot be given

f) If participants fail to bring completed Questionnaires to the first lab, it is not necessary to schedule a second lab solely for this purpose. Rather, participants should be given an envelope for the purpose of mailing the Questionnaires back to the site. Payment for the home visit should be contingent upon receipt of the completed Questionnaires.

VIII. OVERVIEW OF TRAINING

The 36-month home visit consists of several different components. Training guidelines for each of those components are included in the appropriate Sub-Manuals. This section reviews procedures for general training for visitors.

In addition to their training on the various components, visitors will need training in the general flow of the visit and in responding to the kinds of situations that may come up.

Representatives from each site will be trained on the components of the 36-month home visit. Visitors will be expected to be familiar with the 36 month home materials and to have done 3 to 5 home visits before attending the training sessions. Videotapes will be required. Sites will send representatives to a training session in Little Rock, Arkansas, September 19-21. Once all the participating visitors are trained on each of the components, they should practice putting it all together at their sites. Home visitors will need to make a number of visits, probably to the pilot families, during which they do the entire sequence of components "for real", before they start visiting the 120 official families. Criteria for "certification" of home visitors are described in the submanuals.

ADDENDUM TO CHAPTER 28.2
PROCEDURES FOR ADMINISTERING THE BRACKEN SCALE OF BASIC CONCEPTS

I. Procedural Clarifications

(1) On page 6 of the manual (Chapter 28.2) it is stated that the sections for Place of Testing and Chronological Age need to be recorded. This is incorrect however, RA's should not record these two items.

(2) Please note that in Section IV of the Bracken the first item has been changed. It should read: "Show me the picture that has the fruit that are different." All other items are to be read as usual, "Show me (item as printed on protocol)."

(3) For Bracken test pages in which more than one question is asked (i.e.colors, letters,numbers,shapes) if a child responds incorrectly to an item, and then later during another question on the same page answers the previous question correctly, wait until the end of that particular subscale (I - V); return to the appropriate page and ask the question again. The response that is given is then recorded, whether it is correct or incorrect.

> **Example:** RA asks on the shapes page, "Show me the star." Child points to the wrong shape. RA records the response to this item as incorrect on the form. RA asks the next question, "Show me the circle," and in looking for the circle, the child points to the star and says "There is the star." RA repeats "Show me the circle," and the child responds. At the end of the subscale, after the child has responded incorrectly three times in a row, the RA returns back to the shapes page and says, "Show me the star." Whatever the child responds at this point is the answer that should be recorded on the form, whether it is correct or incorrect.

(4) For pages in which just one question is asked (the pages with four panels) if a child responds incorrectly and then, before the RA turns the page, the child points to another response or verbally indicates another response, ask the child the question again. Whatever response is given is then recorded, whether it is incorrect or correct.

(5) Some RAs wanted to know if it is acceptable to say "Good job" to the child after a Bracken item is answered. This is acceptable as long as it is not only said when the child gets the correct answer. However, it is better to reinforce the child by saying "Good pointing" or "Good Answer".

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II. What if the Child Refuses an Item or the Test

(1) If a refuses or stalls after the initial question is asked by not pointing at an item on the first prompting, repeat the item one more time. If the child still does not answer then mark the item as incorrect and move on to the next item. This allows for a total two prompts after the initial question is asked.

(2) In cases where the child refuses to do the Bracken, RAs can try to administer the Bracken later in the home visit or in the lab, if this is possible. All deviations from the normal procedure should be documented, however, in "Other Relevant Observations" on the bottom of the 36 month Bracken Rating Form. If the Bracken is not completed at any time it will be considered missing data and will not be scored as 00.

III. Monitoring Testers Update

People who fail the 5th Bracken (or whatever number Bracken is sent) need to send in the 20th Bracken after that one. Those who pass the 5th Bracken do not need to do this.

CHAPTER 28

Section 2

PROCEDURES FOR ADMINISTERING THE BRACKEN SCALE OF BASIC CONCEPTS

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CHAPTER 28

Section 2

PROCEDURES FOR ADMINISTERING THE BRACKEN SCALE OF BASIC CONCEPTS

I. OVERVIEW

The Bracken Basic Concept Scale consists of a full scale diagnostic instrument and two screening tests. We will be using the School Readiness Composite (SRC), a composite of the first five sub-scales of the diagnostic scale: Color, Letter Identification, Numbers/Counting, Comparisons, and Shape.

Each site should order the Bracken kit and forms from Psychological Corporation (1-800-228-0752). You may need two sets to permit scheduling flexibility.

II. SETTING UP CONDITIONS FOR TESTING

A. Explanation to mother

If the normal order of administering study procedures is followed, the Bracken will be given to the target child right after the initial warm-up (lasting 15 minutes) is complete. After you complete this opening warm-up, which includes some general chit-chat and an overview of the visit, explain to the mother that you would now like to spend about 15 minutes asking the child some standard questions about what CHILD knows while she (the mother) fills out some questionnaires. Give the mother the instructions for the questionnaires and establish where she will fill them out. Then ask her for any assistance or suggestions that you need to set up the setting for administering the Bracken.

"I will be showing CHILD some pictures and asking her questions about them. Some of the questions will be very easy for her. Others may be quite hard. I know that it is difficult sometimes to see your child solving problems and not help her, but it is important that you not talk to her or give her any assistance. Children can sometimes surprise you by giving answers you never thought they knew."

NOTE: If the mother has already completed the Questionnaires you should obviously eliminate that component of the set of directions for the Bracken that make reference to the Questionnaires.

There will be times when mothers will not be filling out questionnaires for some reason and are present when the interviewer is administering the Bracken. Some of these mothers may become concerned when their children do not answer all of the items correctly. In order to assure these mothers and insure that the administration goes smoothly without any interruptions, the interviewer should preface the session with an introduction similar to the following. (Note: this does not have to be said exactly as written, this is just a guide for what an interviewer might say.)

"This test is designed to show us some of the things CHILD knows, some of the things s/he is just learning and some of the things s/he does not know. Because this test is designed to be used for children 3 to 7 1/2 years old, there are likely to be many things that CHILD does not yet know. That is to be expected and there is nothing to be concerned about when s/he does not know several of the answers. We are required to ask a certain number of items that s/he will not know. That is done so that a score can accurately be measured. So, remember that there is nothing to be concerned about if CHILD does not know all of the answers."

B. Physical setting

You will need to select a place to test the child that is as free from distraction as possible. If the room where you have conducted the Warm-up is quiet, it may be the best possibility. If not, ask the mother if there is a place in the house that would be suitable or try to eliminate noise in the room. (e.g. if a TV or radio is on, ask if it can be turned off for a few minutes)

Here you want to ask the mother for help in setting up the Bracken administration. Once you and the child are settled and ready to begin testing, hand the mother the first set of Questionnaires. Give her the following instructions:

"Now I'd like to spend a short time asking CHILD some

standard questions about what he/she knows. While I am doing that, I have some questionnaires for you to fill out yourself. You may remember seeing some of these before. I want you to fill them out thinking about what is happening right now or how you feel about things at the present time. If you have problems with any of the questions, we can discuss them after I finish talking with CHILD. If CHILD or I need your help, I will ask (call) you. Before filling out each questionnaire, please read the instructions at the top of the form."

In certain situations the mother may not be able to complete some or all of Questionnaire Set I while you are administering the Bracken. Questionnaires which are not completed during the Bracken can be administered between Section I and Section II of the Standardized Interview. For more information about how to handle changes in questionnaire administration, please refer to section V. of Chapter 28.4.

The test can be administered in the same room with the mother, but it should preferably be done in another room. The decision will depend on the physical conditions in the home and the child's willingness to leave the mother's presence.

It is very important to try to seat the child in a chair at a table rather than on the floor. It is much easier to control the child's attention and concentration at a table. A child-size table is ideal. A second choice is an adult-size table (e.g. kitchen or dining room). Seat the child at an appropriate height for the table. If no table is available, you will have to seat the child and yourself on the floor. Do anything you can to make a contained space for you and the child (e.g. sit in a corner, or against some furniture).

Seat yourself at a 45-degree angle to the child. Responses on the Bracken involve pointing at the stimuli presented. The stimulus book should face the child, but you must be able to see where the child is pointing.

C. Enlisting the child's cooperation

During the warm-up period, you will have spoken to the child at least occasionally. Many children will be eager to talk to you. When you are ready to administer the Bracken, say something like the following to the child, "I have been talking to your mommy and asking her questions. Now I have some things for you to do. See this book? It has some pictures in it I'd like to show you. I'll ask you some questions. OK? Let's sit down here so I can show you the pictures." Follow instructions on pages 23-24 in the Bracken manual.

Testing a young child is an art. Here are a few guidelines.

1. Be moderately directive. Say, "I'd like to show you some pictures." Don't say, "Would you like to see some pictures?" If you ask "Would you like...?", lots of children will say no. Then you are stuck. Don't wait for the child to take the initiative. Children will expect you to take the lead. That does not mean that you should coerce or pressure the child,

but that you should exhibit confidence and a positive attitude.

2. Know your test materials intimately so you don't waste time once you have the child involved. Be able to move smoothly and quickly through the materials. Even brief delays often lose young children's interest.

3. Children often introduce distractions and irrelevant conversation. If the child starts conversing about something else, e.g. "I got a new toy," listen for a moment, then try to get the child back on task. Often you can offer to continue the conversation or do something else when you are through with the pictures. e.g. you might say that "That's great. Maybe after we're through here you could show me your new toy." or, "I'll bet that is really fun. Now let's try this picture." or "We just have a few more of these to finish. Then you can tell me more about ....."

III. ADMINISTRATION OF THE TEST

A. Preparation

You will need the Examiner's Manual, the Stimulus Pictures, and a Record Form. Fill out the first page of the Record Form as follows:

Put only the child's ID number, not the name on the first line.

Fill in the sections for Place of Testing, Tested by (put ID number for examiner), Date Tested, Date of Birth, Chronological Age.

Please note that the materials in the Bracken Kit are very fragile. It is recommended that each page is placed in a plastic notebook size envelope/page or is laminated for protection.

B. Giving the test

Follow the administration procedures in the Bracken Examiner's Manual for the 5 School Readiness sub-tests: Color, Letter Identification, Numbers/Counting, Comparisons, and Shape. Record answers on the Record Form. Note that you begin with Item 1 on each sub-test. You discontinue the sub-test after 3 consecutive failures. When you complete all five sub-tests, check to be sure you have reached 3 consecutive failures in each sub-test. If not, go back to any items you missed and administer them.

The stem for several of the items have been changed from what appears in the Bracken instruction manual. The training videotape provided by the UNH site will include these changes. Please follow procedures as instructed on the training videotape.

Interviewers should be keenly aware of their body language and facial expressions while administering the Bracken as they can give hints to a child about what you expect -- whether the child gave a correct answer or whether the child is doing what you want him/her to do. Just a slight widening of the eyes, a lift of the eyebrows, or shifting in your seat can lead the child to answer as s/he thinks you expect or want him/her to do. Even the time you wait for the child to respond can influence his/her answer -- wait the same amount of time between asking the item and moving on to another if the child does not answer. Keep eye contact constantly until the child has answered or until the allotted time to move on to another item if s/he does not answer (breaking eye contact indicates you are no longer waiting or interested in what the person has to say). Practice keeping the same expression, the same body language and practice keeping your responses the same throughout the administration and from administration to adminsitration.

C. Scoring

Data from the Bracken will be entered at the item level. Send the completed form along with the DM-I cover sheet which provides the child ID number, date of the test, and Interviewer ID number.

IV. PROBLEMS THAT MAY ARISE

A. Child refuses to begin the test

If the child is reluctant to sit down and begin the test, spend a few minutes talking and playing with the child. You may also ask the mother to sit with the child at first to make the child more comfortable. Be flexible. If the child is quite resistant, wait a little while and try again.

B. Child fails to respond

As the manual indicates, ask the child to "Think about the pictures carefully and choose the best one." If the child still does not respond, ask the child to "Take your best guess."

C. Child refuses to stay at the table

If the child insists on getting up and wandering around, ask the child if he/she would like to sit on your lap. If not, you can enlist the aid of mother and suggest that the child sit on mother's lap. If the child squirms and focuses more on getting down than on the task at hand, try presenting the task with the child seated on the floor.

D. Child looks to mother for help

Before the testing you will have cued the mother that there will be some tasks that the child will not be able to do. Furthermore, you will have told her that she should not assist unless asked to do so by you. A reassuring "You do it." said to the child by the examiner and/or mother may help the child along. Another thing you might say to coax a child: "I've already asked your mommy some questions. These questions are especially for you."

E. Mother talks nonstop at the child telling her how to answer

Before the testing, you will have emphasized that you do not expect the child to do all the tasks presented. If the mother begins to constantly direct the child, you must gently remind her of that expectation.

F. Mother insists the child can do something that she just failed to do

You might first say, "Yes, that sometimes happens with procedures like this." Then explain to the mother that you are interested in the child's performance at that moment and that you realize that you won't necessarily see the child's very best performance. You might also explain that the test takes this into account. Provide other reassurances, if the mother seems to need them (e.g., the child is doing well).

G. Mother asks you what the child's IQ is

Explain that the test is short and doesn't really measure IQ. If you can, reassure the parent that the child is performing well. You can show the mother the items or information that the CHILD got correct and incorrect. If the mother still has questions about the child's performance, you can ask if she would like the PI to call her to talk with her more about the testing.

H. Siblings interrupt the testing by wanting to see the materials or give answers

If there is a second visitor, that person should entertain the sibling(s). That visitor can even play a similar "game" with the sibling. You may want to bring some additional materials and toys for the siblings to play with. If there is no second visitor, ask the mother to entertain the sibling even if it means the mother has to interrupt filling out the questionnaires. Your first goal is to get a valid test from the child. The mother can always finish questionnaires after you complete the testing.

V. TRAINING AND CERTIFICATION OF TESTERS

To prepare to give the Bracken, the examiners should follow these steps:

Read the manual. Chapter 1 gives basic information about the Bracken. Specifics about the development and standardization of the test are contained in Chapter 2. Chapter 3 contains the most important information for your purposes. Pay particular attention to pages 23-24 (Administration of the BBCS Diagnostic Scale). Pay particular attention to strategies you can use so that children do not develop a response set (e.g., Say "Look at all the pictures.") As the manual suggests, reinforce the child's attempt at responding by saying "That was a good answer." Do not directly answer "Yes, that was right."

Each examiner should administer a minimum of three practice tests. Training will take place during the training for the Home

Interview. This is an easy-to-learn, easy-to-administer test. Examiners should bring their questions to the training.

After the training, examiners will videotape themselves administering the Bracken to two 36-month olds. These tapes should then be sent to the UNH site. Based on these tapes an examiner will be judged by trained personnel at UNH as either certified or not certified. Examiners who are not certified will be given appropriate feedback.

VI. MONITORING TESTERS

Because the Bracken is easy to administer, we anticipate that testers will not have difficulty mastering it. Tapes #5 and #20 should be sent to the UNH site. The UNH team will provide feedback to testers having difficulty with the administration of the test.

ADDENDUM TO CHAPTER 28.3
MANUAL FOR THE 36 MONTH H.O.M.E. INVENTORY

1. ITEM #16:

On both the home and child care versions of the H.O.M.E., item #16 reads - Caregiver/parent encourages child to talk and takes time to listen. The manual (Chapter 28.3) states that the key word is encourages. Even so, some three year old children do not need to be encouraged to talk. If this is the case AND THE CAREGIVER/PARENT ACTUALLY TAKES TIME TO LISTEN TO THE CHILD, then this item may be scored as "yes".

If the caregiver/parent reports that the child does not talk much, then visitors must probe and interview to determine if the parent/caregiver actually encourages the child to talk daily AND listens to the child before scoring "yes".

What we are really trying to capture here is the fact that someone is really taking the time to see that the child has a chance to discuss what is important to him/her and is listened to by an appropriate person. For children who do not start talking "about their day" on their own, then the appropriate adult in the situation (home or child care setting) must try to get them to do this (encourage). If, on the other hand, the child can and does start talking "about his/her day" spontaneously (and does so most of the time), then as long as the appropriate adult in the situation listens the intent of the item is met.

In the case of the children who do not need to be encouraged to talk, it would be wise to probe for how frequently this occurs and the amount of time the adult actually spends listening.

2. Electronic/Computerized Toys:

This section deals with how to handle the electronic/computerized toys that may be used by the child to self teach various skills. (An example is a toy which can be turned on with a button and has a card that is slipped into a slot. The toy will then instruct the child to press the yellow button. Once a button is pressed the toy will then tell the child whether or not s/he was correct.) Some of these toys have a variety of "cards" and cover several areas such as colors, numbers, shapes, letters, etc. If a situation is encountered in which the child has access to these kinds of toys, the observer may credit the mother or caregiver (depending upon the situation you are visiting), provided that she taught or helped teach the child how to use it and the child is in fact using the toy at least once every two weeks. The item that the observer would credit for the toy would depend upon the type of skill(s) that the toy teaches. If the toy teaches several skills, the observer may count it as one toy for each of the skills, provided that the mother or caregiver taught or helped teach the child how to use it and the child uses it for each of the skills at least once every two weeks. For example, a toy that has cards for colors, numbers, and shapes would count as one toy for item #1 (colors and shapes) and one toy for item #6 (numbers).

Remember that each of the toys alone, for item #1, do not have to teach all three areas. Though there must be two or more toys which will cover all three areas in order to credit the item. There may be a donut shape sorter which is used for teaching color and shape, and a donut stacker which is used for teaching sizes. This would be two toys which teaches all three areas, and therefore, credit may be granted to item #1. There may also be a book that teaches shapes, a game that teaches color, and a puzzle that teaches sizes. In this case there are more than two toys which teach all three areas, and therefore, credit may be given for item #1.

CHAPTER 28

Section 3

MANUAL FOR THE THIRTY-SIX-MONTH H.O.M.E. INVENTORY

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CHAPTER 28

Section 3

MANUAL FOR THE THIRTY-SIX-MONTH H.O.M.E. INVENTORY

I. INTRODUCTION

A. The H.O.M.E. Inventories

The H.O.M.E.(Home Observation for Measurement of the Environment) is a standardized instrument designed to assess the quality and quantity of support and stimulation provided to the child in a home environment. It assesses the physical, organizational and social aspects of such environments. The H.O.M.E. is administered using a combination of observation and interviewing techniques. It must be administered while the child is present and both awake and alert. A binary method of scoring is employed. The Early Childhood version of the H.O.M.E. is used with children 3-6 years of age. There are 55 items clustered in eight subscales: Learning Materials (Items 1-11); Language Stimulation (Items 12-18); Physical Environment (Items 19-25); Responsivity (Items 26-32); Academic Stimulation (Items 33-37); Modeling (Items 38-42); Variety (Items 43-51); and Acceptance (Items 52-55).

Information about the basic concepts upon which HOME was organized, the framework for gathering data as part of a visit, and assumptions about how the visitor affects family functions during the visit can be found in Chapter 15.4 (Section II.4).

B. Assuring Validity of the Early Childhood H.O.M.E. Inventory

The Early Childhood H.O.M.E. Inventory is being used as a component of the 36 month home visit. It is designed to supplement information obtained from other instruments used during this assessment period. Therefore, it is **extremely important** that this instrument be scored based on the criteria listed in the item definitions for the 36 Month H.O.M.E.. The H.O.M.E. was standardized using certain definitions as criteria for "yes" and "no" scores to each item. Visitors must use these criteria for scoring the H.O.M.E. at the 36 month assessment. If not, the data will not be valid. **Visitors must not use the definitions from other instruments or from their own values as criteria for yes/no scoring on the H.O.M.E.** If, at any time, unusual circumstances occur during a home visit and the visitor is unsure of how to score an item, that visitor may call Dr. Judith Brisby at the Arkansas Site (501-569-3422) for help in determining a score. (It is prudent to gather as many facts as possible in order to present the situation completely, which will result in the most accurate score.)

C. H.O.M.E. Reliability Visits

Each site should conduct a minimum of 6 reliability visits on the Early Childhood H.O.M.E. These reliability visits should be spread throughout the assessment period. For example, if a site has two home visitors each visitor would perform 3 reliability visits, making a total of six visits. Visitor A would administer 3 H.O.M.E.s with visitor B scoring for reliability only. Visitor B would then administer 3 H.O.M.E.s with visitor A scoring for reliability only. If every 15-20 visits are reliability visits, the two visitors would have completed a total of 6 visits for their site. For sites having 3 visitors, each would perform 2 H.O.M.E.s and score for reliability on 2, making a total of 6 reliability visits. The visitors should be paired A/B, A/C, B/A, B/C, C/A and C/B. For sites having 4 visitors, each should administer AT LEAST 1 H.O.M.E. and score for reliability on 1, making a total of AT LEAST 8 reliability visits. The visitors should be paired A/B, B/C, C/D and D/A or some configuration which prevents the observer being the administrator for the person s/he observed (example if A administers and B observes, then when B administers, someone other than A should observe). For sites having more than 4 visitors and/or personnel changes in the number of visitors during this assessment period, the site should use its best judgment in pairing the visitors and spacing the reliability visits throughout the period of the 36 month assessment, always grouping for the most different pairings possible and adhering to the rule of each visitor both administering the H.O.M.E. AND scoring for reliability (sites would always have two visits for each RA).

II. THE H.O.M.E. IN THE 36 MONTH HOME VISIT

A. When To Do The H.O.M.E.

The H.O.M.E. is administered as part of the 36 month home visit. The order of presentation of the visit is: (1) 15 minute Warm-up Period; (2) Bracken (with mother completing the Set I Questionnaires); (3) Interview Portion of the H.O.M.E.; (4) Interview Sections I and II; (5) Set II Questionnaire(s); (6) Checking Questionnaires; (7) Ear Infection Data Collection; (8) Updating Addresses/Phone numbers; (9) Post Visit Interview; and (10) Debriefing, Payment, and Preparation for next contact.

The interview portion of the H.O.M.E. is administered following the Bracken. (If the mother has not completed all of the questionnaires in Set I, simply have her finish the questionnaire she is working on and move right onto the interview portion of the H.O.M.E. The remainder of the questionnaires can be administered between Sections I and II of the Standardized Interview.)

Observations for the H.O.M.E. should be scored from both the 15 minute Warm-up period and from the interview portion of the H.O.M.E. The child must be awake and alert during the observation time. To assure that at least one hour total of the home visit is devoted to H.O.M.E. observation, the interview portion of the H.O.M.E. should last at least 45 minutes. If the interview items are completed in less than 45 minutes, the Visitor will need to continue talking with the mother and observing until 45 minutes have elapsed. **If the interview portion of the H.O.M.E. lasts**

longer than 45 minutes, keep observing and scoring for H.O.M.E. items until the interview is complete. In this case you will have more than one hour of observation time.

Observations noted during the Bracken and the Standardized Interview and Questionnaires cannot be scored. For the observation, the mother and child must have the opportunity to interact. The two do not have to interact, but the opportunity (meaning the time) for them to interact must be there in the visit. Visitors should not collect any data during the administration of the Bracken because the mother cannot interact during this time. We are not collecting H.O.M.E. data during the Standardized Interview and Questionnaire portion of the visit because not all children may be present during this part of the visit. Thus, only score observations relevant to the H.O.M.E. during the warm-up period and during the interview portion of the H.O.M.E.

If the order of the visit needs to be changed due to the child being asleep when the Visitor first arrives, you will complete the Warm-up period observation when the child first becomes awake and alert. See Chapter 28.1 for more specific instructions of what to do in this case. If the child becomes sleepy or falls asleep during the H.O.M.E. and you have completed at least a total of 45 minutes of observation time, finish the H.O.M.E. interview with the mother. Note this shortened observation time on the Home Visit Report (Form 39X). If you were not able to complete a minimum of 45 minutes of observation time, you will need to schedule another visit. This situation should also be noted on the Home Visit Report Form.

In sum, the visitor may count behaviors, physical environments and/or objects observed during the Warm-up period and the interview portion of the H.O.M.E. These observations should total at least one hour. Observations of the neighborhood may be made from observations noted on the way into the house or noted on the way out of the home. No other observations may be made outside the allotted time frame.

Visitors must not use definitions and/or scoring procedures from any other instrument as criteria for determining "yes" and "no" scores on the H.O.M.E. Only those criteria listed in the Early Childhood H.O.M.E. item definitions can be used to determine scoring on this instrument. Each measure in the NICHD Study of Early Child Care is independent of all others. Each has its own specific intentions and purposes. Each measure will only be useful if it is administered in strict accordance with its particular purpose.

B. Where To Do The H.O.M.E.

The Early Childhood H.O.M.E. is administered in home settings. The home setting refers to the child's primary residence (house or apartment). Because the instrument is designed to describe the child's environment in a **home-like** setting, it is not administered in an office, a laboratory or an institutional setting such as a child care center.

C. Time Parameters of The Home Day

For children in alternate care it is important to distinguish between the child's experiences at home and the child's experiences in alternate care. Therefore, when gathering data needed to score the H.O.M.E. Inventory, it is essential to carefully separate the experiences a child has during the time periods at home from the experiences the child has during the time periods in alternate care.

For purposes of asking questions and probing for details needed to score the home version of the H.O.M..E. Inventory, it is essential that data gathered refer only to that portion of the day when the child is with his/her family. The following examples define the time periods for data collection:

1. If the **child goes to** an alternate care situation (center, family daycare home, grandparents, etc.), the home visitor would **not** collect information about anything which occurs from the time the mother drops the child off at the care situation until she picks the child up again. DO NOT collect data on objects, events, or transactions that occur during the time in alternate care. If the mother does not drop the child off (father or someone else takes to the care situation) at the alternate care situation, the home visitor would not collect data about the child's experience from the time the child leaves the home until the child returns.

2. **If a caregiver comes to the child's house**, home visitors would not collect data about the child's experiences beginning from the time the caregiver arrives in the child's home until the caregiver leaves. Caregivers in this situation may be baby-sitters, nannies, grandparents, etc. **No data would be collected for the time period in which the child is in the care situation.** In those situations where a caregiver comes into the home and the mother remains in the home (as with mothers who work at home), home visitors would not collect data about the child's experiences for that period when the caregiver arrives at the home until the caregiver leaves.

3. In situations where **the caregiver lives in the home** with the child, the home visitor would **not** collect data about the child's experiences from the time the mother leaves (and the caregiver assumes the full caregiving responsibility) until the time the mother returns. The live-in caregiver may be the father, a nanny/nurse, grandparent, sibling, other relative, etc. If the caregiver lives in the home with the child and the mother works in the home, the home visitor would not collect data about the child's experiences from the time the mother begins work (and the caregiver assumes full responsibility for the child) until the mother stops

work (and the caregiver no longer has full responsibility for the child).

4. In situations where the **mother is a caregiver in her own home** and cares for other children as well as the study child, home visitors would **not** collect data dealing with the period from the time the first child (who is a non-family member) arrives for alternate care until the last child (who is a non-family member) leaves. It is important that home visitors collect data only during the time the child is at home with **no** non-family children present who are being cared for by the mother. The child care observers will collect data on what happens during the child care (alternate care) day. These are separate environments and must be treated as such for data collection. The following section describes the purpose of the time period differences.

D. The Mother As A Care Provider In Her Own Home

At the 36 month assessment period, the Early Childhood H.O.M.E. Inventory will be administered in homes where the mother provides care for the study child as well as other children. These homes will receive two H.O.M.E. Inventory assessments. One will be administered by the home team for the time period when the mother **is not** caring for children other than her own. The second will be administered by the child care team for the time period when the mother **is** caring for children other than her own. There are two basic reasons for this. First, the home environment and the caregiving environment are two separate situations. It is possible that there are differences in what occurs in each, especially in the areas of responsivity, academic stimulation, modeling and acceptance. Unless these two environments are assessed as separate entities, it will not be known what differences might occur. Secondly, it is probable that, by the time the study child is 36 months old, the mother, who is a care provider in her own home, may also be caring for infants. If so, it is likely the infant(s) may demand more of her time, leaving less time for interaction with her own child, during the child care day. It is important to determine if this occurs and why it occurs (does it depend on the number of children in the alternate care situation, the ages of the children present, etc.). Thus, it is important that the two environments be assessed as separate situations.

III. ADMINISTERING THE H.O.M.E.

A. The General Purpose Of Administering The H.O.M.E.

The general purpose for administering the Early Childhood H.O.M.E. is to give a different perspective on the home environment from the perspectives offered by other procedures used to characterize the child's experiences in the family environment. H.O.M.E... is designed to look at the home environment from the child's point of view--**what the environment offers the child.** This last sentence is important. Home visitors should keep it in mind, as it is the guiding premise upon which cut-points should be based when determining scoring in borderline situations.

B. How The H.O.M.E. Is Administered

Although the Early Childhood H.O.M.E. is a systematic measurement of the home environment, it is administered in an informal manner using a combination of observing and interviewing. The observation period for the H.O.M.E. should be based on a one hour time frame including the 15 minute Warm-up Period and the interview portion of the H.O.M.E., which will last a minimum of 45 minutes. Observations and information obtained during the administration of the Bracken and the Standardized Interview and Questionnaires **may not be used** in scoring H.O.M.E. items.

For the home visit, there are certain observations which must be made based on the interactions of the mother toward the child. These interactions cannot be scored based on what other household members do. These items are: #15, #17, #27, #28, #29, #30, #31, #32, #40, #52, #53, and #54.

C. The Home Visitor's Role

The home visitor's role is vital in administering the H.O.M.E. It is the visitor's responsibility to gather a **complete** picture of the usual circumstances the child is exposed to in the home environment. In order to do this the visitor must be thoroughly familiar with the items on the score sheet and all item definitions. In addition, the home visitor should carefully study all training materials provided and should keep abreast of all information regarding the H.O.M.E. (newsletters and updates) provided by the DCC, the Arkansas Site, and Aletha Huston (coordinator for the 36 month manual). Each visitor in training should then accompany a trained visitor on several home visits to become familiar with the procedure. The number of visits depends on the individual visitor's needs. Several practice H.O.M.E. administrations should be done by the trainee, accompanied by an experienced home visitor. The trainee and the experienced visitor should separately score all items, then later compare and discuss scores on each item. The home visitor should then follow the procedures for certification (detailed later in this section). Once the visitor is certified in the Early Childhood H.O.M.E., she may begin data collection.

It is the home visitor's responsibility to set the stage for the proper mood--one in which the mother is at ease, not threatened, not defensive and thus, open to conversation concerning what the child experiences while at home. Remember, home visitors are trying to "see" the most natural circumstances possible--those most nearly like what the child experiences on a daily basis. There are several things the home visitor can do in order to arrange the atmosphere so this can happen. These include:

Be Totally Neutral - It is important that the visitor in no way show her approval or disapproval of anything the mother says. Mothers, caregivers and child development experts tend to think that what they do and believe concerning child care is correct. Visitors should avoid conveying their feelings in any way. Home visitors should be careful not to ask for information in a leading manner, not to share their views in personal conversations and not to mark the score sheet in a manner which would make the mother think she said something wrong. (This can occur by the visitor asking a question, getting an answer and then quickly marking the score sheet.)

Speak the Mother's Language - The home visitor must gear her language level to match that of the mother. It is insulting to talk down to a mother. It is also insulting to use technical terms with which the mother may not be familiar. Usually, a few minutes into the visit, the visitor can gauge the mother's language abilities and comprehension and appropriately match it.

Use Body Language To Advantage - How a person speaks with their body can, in many ways, be more telling than what the person says. There are a few basic things a visitor can do to avoid conveying a message that is insulting or disapproving. They are: Don't raise your eyebrows at something the mother says; don't let your eyes widen at something the mother says or does; don't smirk; never sit where your eyes are above the mother's (where you would have to look down on her--yours may be lower or level with hers, but looking down on her gives a psychological feeling of being beneath you); match your body posture to that of the mother (lean back if she does, lean forward if she does); never fold your arms over your chest (it makes you appear to be closing yourself off from the mother); if the mother sits on the floor, you should sit on the floor also; and always cross your legs turned in toward the mother.

Be Genuine - A visitor should enter the visit process with the attitude that she is going to meet a new friend and discover what that new friend does during the day while she is at home with this study child. A visitor who can truly be interested in the mother and study child as people will have no difficulty in projecting the elements necessary for the visit to run smoothly. People respond to sincerity--usually by telling you everything you need to know to insure complete, accurate data.

D. Style and Delivery in Administering the H.O.M.E.

Visitors who were employed in this study during previous assessment periods know there are as many styles of administering the H.O.M.E. as there are people administering it. Each visitor should begin to "have a feel" for what works best for her after several practice sessions. Suggestions will be provided on how to approach certain interview items (in the item definitions). However, each visitor must determine what works best for her and use that personalized method in data collection. It is possible that she may need to use several approaches in delivery to meet the demands different situations present.

The visitor needs to keep several things in mind when working on style and delivery. They are: be at ease; try to put the mother at ease; ask questions in such a way that the mother is not put on the defensive; do not ask leading questions (i.e. questions which encourage the mother to "second guess" what the visitor thinks is the "right" or "expected" answer); be approving and accepting of the mother's opinions and behavior.

Information for scoring the items on the Early Childhood H.O.M.E. Inventory is gathered in two ways--observing and interviewing. It is the visitor's responsibility to determine what is present or what occurs regarding each item. If an item is not observed, ask about it. If an item is discussed and the response is not clear, probe until it is understood. **The visitor is the instrument,** the score sheet is not the instrument. The score sheet provides only a record of what the instrument found concerning the items listed there. Those items require much more in-depth information in order to evaluate a "yes"/"no" score than just reading/asking them.

The H.O.M.E. assessment is based upon information gathered in the home setting both from observing behaviors between the mother and the child and physical aspects of the home situation and from interviewing the mother about certain happenings which normally occur. It is often useful to begin the administration of the H.O.M.E. by offering a compliment to the mother or the child upon entering the home. The interview items should be administered after the Bracken. Observation items may be scored at any time during the Warm-up period, the interview portion of the HOME and Interview Section I, but not during the administration of the Bracken and the structured interview. The visitor may also score

H.O.M.E. safety items noted during the walk into the home/apartment and on the way out of the home/apartment. It may be necessary to walk or drive by play areas that are not connected to the home (such as a park or playground a block or two away). If the play area is not located adjacent to the home, the visitor should walk or drive the route the mother and child would follow in going to the area, scoring from those observations.

It should be reiterated here that the items, as they are listed on the score sheet, are to be used as a guide to the intent of the item and a reminder to the visitor of what to discuss. Asking the items as they are worded on the score sheet will not provide sufficient information for scoring. Often a visitor will need to use as many as 6-8 questions or probes in order to accurately score an item. Life is sometimes complicated; people's responses are sometimes hard to interpret. Just turning each item as it appears on the score sheet into a question will not gather sufficient data to give a true picture of a child's environment.

All observation items, items which deal with the availability of materials and items which do not contain a qualifier (such as in the past week, so many times a week, etc.,) **must be based on what is seen and is present at the time of the visit** - not what was there last week, the day before, or will be there next month.

E. Observing In The H.O.M.E.

Thorough knowledge of the items on the H.O.M.E. will help ensure that the visitor will look for the items which can be scored from observation alone. In situations where the mother says one thing occurs but the visitor sees the opposite happen, the observation outweighs the interview. If the visitor has received conflicting observation and interview reports, and still has concerns as to which is the most usual occurrence, she should probe further until there is a clear answer.

For the 36 month home visit certain observable items must be restricted to those behaviors exhibited by only the mother. Those items are: #15, #17, #27, #28, #29, #30, #31, #32, #40, #52, #53, and #54.

Certain items on the H.O.M.E. can be scored from **observation alone. They are: Items #15, #17, #19, #20, #21, #22, #23, #24, #25, #27, #28, #29, #30, #31, #32, #40, #48, #49, #52, #53, and #54.** Item #55 may be observed, but it is usually necessary to discuss the type(s) and frequency of the punishment used.

The following items are usually observable, but may need to be probed to determine their availability to the child and how they are used with the child to meet H.O.M.E. definition criteria for scoring: items #1, #2, #3, #4, #5, #6, #7, #12, and #43.

The following items may be scored from observation alone, but need to be discussed if they are not observed: items #8, #39, and #49.

Visitors must remember that all items on the H.O.M.E. need to be covered. However, the opportunity to observe something needed to score an item may not occur. In such instances, the visitor will need to discuss the issue with the mother in order to score the item.

F. The Interview Portion of The H.O.M.E.

Interviewing for the items that are not observable must be done in a manner which will elicit the desired information, yet will not cause the mother to lie, "second guess", or answer incompletely. Again, as in observing, a complete knowledge of all items and their definitions will be the best preparation a visitor can have before attempting to administer the H.O.M.E.

The item definitions will provide some examples of how to pose questions for items. It is important for the visitor to remember, however, that their goal is to get enough information on an item to answer it either "yes" or "no" with confidence. Visitors should not be so concerned with subtle wording (or using the exact wording contained in the manual or as seen on training tapes) that they gather incomplete data. If you want to know something, ask. If you still do not understand, explain what you do not understand. **But get the information.** Visitors must enable the mother to give a truthful and complete answer, but take care not to lead the mother toward giving a particular answer.

Before beginning the interview portion of the H.O.M.E., it is helpful to explain to the mother that you have some questions dealing with what the child does while at home. The visitor should then explain 1) she has a few questions that are being asked of all mothers, 2) she will be marking those as they are discussed, and 3) she will also be taking some notes so she does not forget anything. One requirement of this study is that the visitor start the interview process by saying, "We are interested in learning what types of things (child) does while he is here at home. We are interested in the types of toys he plays with, the places you go--just what a typical day is like. One of the best ways to do that is for you to explain what a typical day is like for you and (child). You may want to start from the time (child) gets up in the morning and just tell me what usually happens during a typical day." Visitors do not have to say these exact words, but should start the interview portion by explaining that they will be taking notes (the reason for looking at the score sheet and writing on it) and asking what a typical day is like.

The items which must be answered by the **interviewing technique are: Items #9, #10, #11, #13, #14, #16, #18, #26, #33, #34, #35, #36, #37, #38, #39, #41, #42, #44, #45, #46, #47, #49, #50, #51, and #55.** Since you will have gained some potentially valuable information about the child (observed during the Warm-up Period and the Bracken performance) scoring other H.O.M.E. items can often be obtained by using probes organized into 4 broad areas of inquiry: (1) outside trips, (2) toys, learning materials and play, (3) family routines and (4) training and discipline.

1. Outside Trips

This area allows easy entry into the family routines. "*Children of (child's name)'s age like to go a lot. Tell me about some of the places you take him/her.*" Then, with simple probes using essentially the wording of the items, information can be obtained for Items #44, #45, and #46. If the grocery store is not specifically mentioned, ask about it and then get the information needed for item #51: *"Do you take her/him with you when you go grocery shopping? Sometimes that can be a real hassle, with the kids wanting everything they see. If that happens, how do you handle it?"*

2. Toys, Learning Materials, and Play

Many of the items in this section requires a specific question, although some of the items in the "Learning Materials" subscale can be scored if the required items are visible during the visit. If some toys or equipment are visible, they can be used as an entry into this area of questioning. For example, with Item #3, you might say something like, *"I see you have a stereo. Does (name of child) have any records or tapes that he/she plays on it?"* Another example might be, *"I noticed that (name of child) was stacking some of those little blocks with numbers and letters on them. Does he/she have any other toys or games that help teach numbers?"* Once you have gotten positive answers to a few of the toy and equipment items, you might use that information as a base to praise the parent's foresight for getting things that help the child learn, and also to ask about other toys or experiences that the parent provides to help learning. For example, *"It seems that you have gotten (name of child) a number of things to help him/her learn. What other toys does he/she have that help teach things such as (colors, motor skills, numbers, reading, shapes, etc?"* (Items #1 to #12 and Item #43.)

Another means of finding out about a child's use of toys and the parents role in encouraging development is to talk about the child's play. You might say, "*Three year olds like CHILD tend to spend a lot of time each day just playing. What does s/he like to play? When? With whom? What toys does s/he like most? What does s/he do when s/he gets frustrated playing?*" You might follow this with "*Do you usually have to set things up for him/her to play, like getting out the toys or setting down with him/her: or Does s/he tend to come to you to play with him/her or to get the toys s/he wants?*" "*Do you do this to help him/her have fun or to keep him/her from getting frustrated or are you trying to get him/her to learn something new?*"

Questions for the Learning Materials subscale provide a good lead into the items in the Academic Stimulation subscale. Sometimes the responses given to the items about toys make it so clear that the parent is encouraging children to learn the things covered in item #13 and Items #33-#37 that no further questioning is needed. If not, the following probes can be used. "*From what you said about CHILD's interest in playing with (type of toy), it sounds like he/she is interested in learning about (colors, numbers, words, the alphabet, etc.) Have you deliberately encouraged him/her to learn about (item), or has he/she just developed the interest on his/her own?*" Depending on the parent's response, you might then ask, "*Tell me what kinds of things you've done to encourage her/him?*"

While talking about things the parent has tried to teach (if such behavior has occurred), a special question oriented to Item #14 can easily fit into the flow of conversation. "*Now that* *she/he is learning so many new things, have you started trying to teach manners, like saying 'Please' and 'Thank you'?"* A similar question so comfortably handles Item #47: "*Are you teaching CHILD to put away some of his/her toys yet, or do you think he/she is still a bit young to do that?"*

3. Family Routines

The area of family routines will yield information for several items. This and the area of discipline are far more sensitive areas than the first two, and care must be taken not to offend the parent or sound judgmental in either a question or a response might make to. A good way to approach this area is to relate the questions more to what the child likes to do than what the parent chooses to do. For example, for Item #16, "*Does CHILD ever like for you just to sit down and talk to him/her? About how often do you do that?"* Another useful technique is to offer acceptable alternatives, using reactions of children as a basis for both. Thus for Item #26: "*Children CHILD's age are very different. Some like to hug and cuddle a lot. Others seem to busy or aren't interested. Does CHILD seem interested in your holding him/her? About how often do you get to do this?"*

4. Training and Discipline

The area of discipline and encouragement of socially responsible behavior is one that is given greater attention in the Early Childhood version of the Inventory. The suggestions offered in Chapter 15.2 about training and discipline are generally appropriate for the Early Childhood scale also. However, the greater range of items on the Early Childhood requires an increase in the range of exploration about the child's behavior and the parent's response. In addition to the items dealing with punishment for unacceptable behavior, there are several items dealing with increased demands for socially responsible behavior. In regard to the punishment time (#55) requiring an interview question: try not to put the parent on the defensive. It is an item that is best not to be attempted during the early phases of the visit. In the normal course of the interview, statements are made by parents that can be used as unobtrusive bridges to this area. For example: "*You mentioned a little earlier that CHILD sometimes gets a little roudy (or sassy or belligerent, etc.) Does he/she ever get so out of control that you feel you have to spank him?*" or "*Most children have times when they are moody (spiteful, disobedient, etc.). Does CHILD sometimes act like that? When it happens do you feel he/she needs a spanking?*"

One approach to items such as #14, #18, #51, #38, #39 could be as follows: "*Once children reach CHILD age, some parents feel that they are no longer babies, that they should have more choices about things like what to ear or what to watch on TV, but also have more responsibility like helping put up their toys or being polite. Do you thing CHILD has reached that age yet?*" Depending on the parent's answer, you can ask any number of questions dealing with the specific items.

A sensitive area of questioning can be Item #41 and #42. One approach to these questions might be, "*Almost all young children* *get mad at times, and most express that anger by yelling, hitting, or throwing tantrums. What do you do when CHILD gets mad and starts to act like that?"* If needed, then follow that question with, "*Most children even get mad a Mom and Dad. They will say something mean to them or even hit them. Has CHILD ever done something like that? How do you handle it?"* This may even be a good place to insert some comment about your own child (if you have one). Example, "*I know that my child used to get mad at me sometimes.*" comments such as these often put parents at ease.

G. Scoring The H.O.M.E.

Scoring for the H.O.M.E. is done using a binary system - "yes" or "no". The situation (mother praised the child twice, the child is taken outside for play every day, the mother encourages the child to learn colors, etc.) either happened or did not happen, thus making scoring an easy task. The ease of the scoring task, however depends on a thorough knowledge of the items and their definitions. There are cut-points for "yes" and "no" scores. These must be followed to the letter because they are the ones used when the instrument was standardized. The use of definitions from any other instrument or from a visitor's own values will invalidate the data. The definitions and examples in this manual will generally provide enough information for scoring items on the H.O.M.E. Occasionally an unusual situation arises which presents the visitor with concerns about how to score an item. When this occurs, the visitor should call Dr. Judith Brisby at the Arkansas Site. Dr. Brisby will discuss the situation and help determine appropriate scoring. Visitors may also call at any time for further clarifications.

H. Exceptions To Standard Procedures

Whenever one tries to define standard conditions under which procedures should be carried out, one immediately has to face the inevitability of more exceptions than standards. In designing the Home we opted for binary (either-or) choices rather than ratings along a continuum, and for arbitrarily selected cutting points ("...no more than one instance of physical punishment occurred during the past week") rather than estimates of quantity and severity ("...uses physical punishment extensively, moderately, minimally"). We hoped to eliminate a great deal of the subjectivity ordinarily associated with similar inventories. With each revision the items became more concrete and, hopefully more objective. However, items that are objective for one family may not be so for another.

For example, many of the items begin "Parent does..." something (reads to child, encourages developmental advance, provides toys, etc.) This wording reflects the orientation that the parent--most typically the mother--is an important person in the life of the young child and will be the major interpersonal influence on the child's development. This does not mean that the parent will supply all the care provided the child. For example, in homes with older siblings, many of the activities covered by

Inventory items might occur in the life of the child but be provided by an older brother and sister. Some mothers have responded to items such as "Parent reads stories at least three times weekly," with a statement such as, "I don't, but the older kids do."

Such exceptions occur frequently. Therefore, visitors should be mindful of an overriding principle which will help in making decisions about the scoring of individual items. The intent of the assessment procedure is to get a picture of what the child's world is like from the child's own perspective. If that principle is kept in mind, then the Visitor will not have to split hairs to score some of the items. The Inventory is attempting to assess the home environment from the perspective of the child is not exclusively appraising the caregiving abilities of the mother. Toys bought for an older child but made available to the key child can still help in the acquisition of eye-hand coordination. Books read by an older child still foster language acquisition. In order to obtain an accurate picture of the home environment, it is critical that we learn a great deal about the input supplied by the parent(s). But, in real homes, support for development can come from any sources. The visitor should both seek and evaluate information about these other sources with reference to the basic question: What is in it for the child?

While the scoring of items on the HOME should always be done from the perspective of the child, the NICHD Study of Early Child

Care imposes some constraints on the home visit that are not typically present when the HOME alone is the focus of a home visit. For example, the NICHD visit is being so that the focus is on the mother rather than on the full array of caregivers, family members, or other household residents that may typically be present in the child's home environment. To the greatest extent possible, the NICHD visit is being conducted in such a way as to reduce (and, hopefully eliminate) input, including distractions, from other household members. These constraints, as important as they are for the purposes of the study, are likely to lead to some "non-normal" behavior on the part of the household members. Accordingly, the decision was made to score those items requiring direct observation of parental behavior in a manner different from what would ordinarily be done with the HOME. Specifically, the items will be scored exclusively on the basis of the mother's behavior during the visit. The items affected are: #15, #17, #27, #28, #29, #30, #31, #32, #40, #48, #52, #53, and #54. When scoring these items, score then exclusively on the basis of the mother's behavior. Do not count the behavior of other households members when scoring the items. This rule applies only to the items just mentioned. For instance, if during the course of the interview you find out that the mother does not encourage the child to talk and take time to listen (Item #16) but the father does, the item should still be scored at "YES". The same would also be true for Items #18, #26, #47, and #51, etc. (i.e., all the items that do not require direct observation of behavior during the actual home visit).

I. Additional Suggestions

1. A moving target

During the early childhood years, the child who is the focus of the EC-HOME visit is much less likely to remain in one place inside the home or apartment than an infant or toddler. The visitor may be uncertain as to whether to remain with the parent or move with the child. Regardless of which action the Visitor takes, either provides an opportunity to make observations that might not otherwise have been possible. If the visitor moves with the child, it allows a better look at the toys and learning materials which are available to the child, and, if the parent wants the child to stay with her, it may provide an opportunity to observe her control techniques.

If the Visitor wants to move with the child, and it is acceptable, it would be appropriate to say something like, "*It looks like CHILD enjoys playing in his/her room (or out in the yard). Would you mind if we went there to talk so I could watch him/her play?*"

2. Including the child in the visit

Some young children are shy and will not become involved with the visitor. However, most children this age are quite curious and very excited to show their toys, exhibit skills (such as counting or singing) and to tell the things that are important to them. Visitors should make a point of including the target child in the visit.

Including the target child by asking questions about favorite toys, singing, saying their ABCs, counting, etc., can be an effective and varied technique for raising subject areas and providing opportunities for observation. **All scoring, however, should be based upon the information/answers provided by the mother -- even if the answers given by the child are correct.** Visitors must also be cautious not to ask the child so many questions that this technique interferes with the mother's responses to the child that are found in the responsivity subscale.

This technique, if used sparingly, will make the administration of the H.O.M.E. seem more like a visit than an interview and help break the monotony of asking so many consecutive questions of the mother.

J. Completing the H.O.M.E. Forms

For the H.O.M.E. score sheet fill in the box beside each item if the behavior is observed during the visit or if the parent reports that the conditions or events are characteristic of the home environment.

All items should be scored, checked, and double checked before leaving the home. Checking to be sure that enough information has been obtained to score each item is important because information obtained at a later time is likely to be less accurate. A visitor may have to call back to ask about something she forgot to ask during the visit, but doing so is clearly not as desirable as obtaining complete information at the time of the visit.

Visitors will want to keep notes throughout the visit on H.O.M.E. items depicting interactions between the mother and child. This is especially true for items which require a specified number of interactions/behaviors to occur for credit to be given. It is easy to forget an interaction/behavior which occurred early in the visit unless some system to help visitors remember is used. Visitors may mark a score on one of the interaction items which occurred early in the visit and then overlook an interaction which took place later in this visit that might change the score.

Always remember that not obtaining enough information will result in a false picture of the home situation.

IV. SUBSCALES AND ITEMS DEFINITIONS

This manual has a definition for each item in the Early Childhood H.O.M.E. Each item also has examples of both "yes" and "no" score situations. The first two subscales also have dialogues between the visitor and the mother to give an example of what probing is necessary to accurately assess the intent of the items. (It is usually necessary to ask several questions rather than just read the item as it is worded on the score sheet.) **A key will be provided at the end of this chapter with scores and reasoning for these interview questions. (In subscales #3 through #8 the conversation for each item is not provided. However, for each item some examples of lead-ins are provided. Each visitor must develop her own style and techniques. These examples provided are designed to help start that process.**

A. General Intent of the Subscales

There are eight subscales in the Early Childhood H.O.M.E. They are:

Learning Materials (Items #1-11) - this subscale deals with the toys, books and games which facilitate learning. (It contains some items that deal with the adults in the home environment and their commitment to their own learning - in effect, adults serve as models as well as providing direct instructional experiences).

As stressed in the instructions for the Infant-Toddler H.O.M.E., scoring on all items relating to toys should be in terms of the function of a toy or piece of equipment rather than its commercial designation. If in doubt about the appropriateness of a given toy, ask the parent to describe it or show it to you and score accordingly. Also, the child should be allowed to play with the toy; it must be kept in a place where he can get to it or the parent must bring the toy out when the child requests it within the bounds of reason (parent would not be required to bring out the drum set after some household members had gone to bed); and third, it must be in usable condition (without broken or missing parts). Ideally, you will be able to inspect the toys visually in order to make decisions about them. If not, it may be necessary to ask detailed or explicit questions in order to determine whether particular toys meet the requirements of the items.

Language Stimulation (Items #12-18) - this subscale deals primarily with the parental attempts to encourage language development through conversation, modeling and direct teaching.

Physical Environment (Items #19-25) - this subscale deals with the items which describe the physical environment in regard to safety, spatial arrangement, and appeal.

Responsivity (Items #26-32) - this subscale deals with the mother's emotional and verbal response to the child and describes the warmth of that relationship.

Academic Stimulation (Items #33-37) - this subscale deals with the parental involvement with the child's learning, and the mother's encouragement of the child to acquire skills and knowledge.

Modeling (Items #38-42) - this subscale deals with the mother's role modeling and encouragement directed toward the child's development of desirable and socially acceptable behavior.

Variety (Items #43-51) - this subscale deals with a family lifestyle that provides a variety of experiences enriching to the child and encouraging of the child's social development.

Acceptance (Items #52-55) - this subscale deals with the mother's ability to accept and understand a young child's negative and exploratory behavior and her ability to deal with it in an appropriate manner.

B. Item Definitions

Unless otherwise noted, all teaching activities (and conscious encouragement activities) must be done at least once every two weeks in order to receive credit.

All items which state that an activity is done by the mother (e.g. mother teaches child simple verbal manners) may be scored if the activity is done by another adult or older child (13 years of age) in the home.

Learning Materials

Item #1 - 2 or more toys which teach colors, sizes *and* shapes are available to the child. These two (or more) toys must afford the child an opportunity to learn about all three areas (colors **and** sizes **and** shapes). No one toy has to offer the child an opportunity to learn all three, but together the toys must make such learning possible. If toys are available which teach only one or two of these areas, credit cannot be given for this item. The child must be allowed to play with the toys freely, in his/her own fashion, and the mother must also use them to teach concepts in each of these three areas. The mother should use the toys to work on all three areas at least once every two weeks for credit to be given. It is the visitor's responsibility to determine how the toys are used to teach these things - the fact that a toy is red or a square is not sufficient to credit this item. The toys must be available to the child or must be available to the child most of the times the child asks for them (meaning the mother generally gets the toys out for the child when asked, except at nap and meal times, etc.). Examples of such toys are shape sorting cubes, pressouts, mailbox, pegboards, etc. The toys must not be designed for someone younger than the child's developmental age, but they may be more advanced, provided they can be used in a productive fashion by the child. The mother does not have to take the sole responsibility for this task, credit may also be given if another adult in the home or an older child (13 years or older) performs the task.

Scoring Examples:

Example: Mother reports having a pegboard, shape sorter, but she never uses them to teach any of these things. Score "No".

Example: Mother reports having a pegboard and a shape sorter and that she uses them about three times a week to teach all three of these things. Score "Yes".

Example: Mother reports having only a shape sorter which has colors, sizes and shapes. She reports using the sorter to teach colors and shapes and even using the big ball and little shapes to talk about sizes - Score "No" because only one toy is used to do this.

Example: Mother reports having a shape sorter which she uses for teaching colors and shapes. She reports she has no toys or games to teach sizes but she does use some construction paper cutouts of a bear family. She made the family and made them in different sizes and uses it somewhat like a paper doll set. She made it originally to teach social awareness, but has found that it is quite effective in talking about sizes--such as the father bear being big, the baby bear being little, etc. - Score "Yes"

Interviewing and Probing Example:

Visitor: I see you have this nice toy that has all these bright colors and places to put the different shapes. I have not seen one of these before. I guess it is kind of like a 3 dimensional puzzle or shape sorter. How does (child) play with this toy?

Mother: Well---he tries to fill up all the spaces with the shapes.

Visitor: Do you ever help him play with it?

Mother: Yes, most of the time he wants me to play with him. Or at least to sit beside him and be the cheering section.

Visitor: When you play with him, how do the two of you play with it?

Mother: It is usually a give and take play. I put one in and then he puts one in.

Visitor: Does he know what the shapes are or the colors?

Mother: He knows red, yellow, purple, orange, blue, and I think he is pretty accurate with green now. As for shapes, he knows circles, and has almost mastered squares, but he really hasn't gotten triangles yet.

Visitor: Have you ever used this toy to help him learn his colors and shapes?"

Mother: Yes, we are using it, because it interests him now. I first used the regular ball shape sorter to get him started on his colors and shapes

Visitor: It sounds like he is really making progress. What about sizes? Does he know the difference in big and little?

Mother: Yes. He even knows middle size if all three sizes are visible at the same time. (You have one of the two praises you will need for scoring "+" on item #30).

Visitor: Do you have any toys, games or learning materials you use to teach sizes?

Mother: I have several things, but what seems to hold his interest the most is a set of nesting dolls.

Visitor: How do you do that?

Mother: I tell him that we are going to take the dolls out. I ask him which is this one and then which one is inside it. Then we repeat the process as we take all the dolls out. The little one is in the big one. This is bigger than this and so on.

Item #2 - 3 or more puzzles are available to the child. These puzzles must have all pieces present. They should be appropriate to the child's age - challenging, yet accomplishable. It is preferable they have more, but the puzzles must have at least 5 pieces each. The key to this item is not whether the child enjoys working puzzles, but whether 3 or more are available to him.

Scoring Examples:

Example: Mother reports having 7 puzzles out and available to the child. Each puzzle has 10 or more pieces. Score "Yes".

Example: Mother reports having 5 puzzles, two have 9 pieces and the other three have 4 pieces each. All are out and available to the child. Score "No".

Example: Mother reports having 8 puzzles. Six puzzles were 12 piece sets, but she doesn't think any except the 3 piece puzzles have all the pieces left - Score "No".

Example: Mother reports having 2 twelve piece puzzles. All the puzzles with fewer pieces have been put away. Score "No".

Interviewing and Probing Example:

Visitor: Often children of this age enjoy working puzzles (or at least dumping them on the floor), does (child) like to work puzzles?

Mother: Not too much of the time. He is not as interested now as he was about 3 months ago.

Visitor: Does he have a favorite puzzle?

Mother: No, not really. Like I said, he is not too interested in them right now.

Visitor: I guess he is just too busy running around to sit still long enough to work them. How many puzzles do you have?

Mother: I have about 4 of the puzzles with just 3 pieces for the younger children, but, I guess, I must have about 8 for (Child) - the ones with about 8-12 pieces.

Visitor: Where are they kept?

Item #3 - Record player or tape recorder and 5 or more children's records or tapes are available to the child. These materials may belong to the mother or others in the family, but they must be available to the child and he must be allowed to operate the record player and/or tape recorder. The tapes and records must be for children. Regular music records or tapes, even if preferred by the child, do not receive credit. A mother who reports the presence of these materials but reports that she only lets the child use them at a certain time of the day would not receive credit on this item. (Exceptions such as nap time, meal time, story time, etc. would not result in a negative score.) These materials must be in working order. All tapes and records must be of sufficient quality to be heard and understood reasonably well. VCRs and videotapes do not receive credit.

Scoring Examples:

Example: Mother has a record player, but (Child) is not allowed to operate it. Score "No".

Example: Mother has a record player and ten children's records and the children are allowed to operate it - Score "Yes".

Example: Mother has a tape player and 12 country music tapes, but no children's tapes because (Child) likes these better. Score "No".

Example: Mother reports having a record player and a tape player. She also has 6 children's music records, but only 3 are in good enough condition to be heard well enough for (Child) to sing along. She does have 5 tapes with children's stories that she has recorded herself. Score "Yes".

Interviewing and Probing Example:

Visitor: Many children this age are learning to sing and dance. Does (child) like to sing or dance?

Mother: Oh yes. All of our children like to do both. We have a music hour and try to learn a new song about every two weeks. (Note that you have information to score item #35).

Visitor: Do they have any favorite songs?

Mother: Yes, they all love that song Barney sings.

Visitor: How did they learn about it? Did they hear it on TV or did they learn it from a record?

Mother: Well, they first heard it when I got them a Barney video. Then when they liked it so much I bought a tape of just all of his music. There are several that are particular favorites. (Child) likes (list songs).

Visitor: Does (child) play the tape himself or do you have to operate the recorder for him?

Mother: He can do it all by himself now. At first I had to show him how to do everything, but I have a cheap tape recorder so I can let him play the tapes himself.

Visitor: Does (child) just go play a tape whenever he wants?

Mother: Any time except when the younger children are taking a nap.

Item #4 - 2 or more toys or games permitting free expression are available to the child. Examples of such materials are: clay; play dough; crayons & paper; paint & paper; finger paints & paper; paste & scraps of paper. Note that paper does not count as one of the toys or games. If the materials available are all in the paint category, it is permissible for the mother to keep these put up. In order to receive credit in that instance, however, the mother must get them out for the child once a day, **if the child so desires.** The mother does not have to take the sole responsibility for this task, credit may also be given if another adult in the home or an older child (13 years or older) performs the task. If crayons & paper, clay, play dough, and/or pasting materials are the toys available, they should be kept available to the child most of the time in order to receive credit. (Most of the time was used here because some mothers may choose to monitor the use of these materials.)

Scoring Examples:

Example: Mother reports her children have clay and crayons and paper available whenever they want to use them. Score "Yes".

Example: Mother reports that (Child) has paint, paste, crayons, clay and paper, but they are kept put up and only brought out when (Child) has been good - Score "No".

Example: Mother reports having paint, paste, crayons, clay and paper. The paint and paste are kept on an upper shelf and brought out when (Child) asks for them. The crayons, clay and paper are out on the 3rd from the bottom bookshelf. The mother reports she keeps these things there so (Child) can go and get them as he wants just like the other toys - Score "Yes".

Example: Mother reports having all these things, but they are put up to keep the baby out of them. Usually once a week, the mother will bring out one of the items for an art project. Score "No".

Interviewing and Probing Example:

Visitor: Sometimes children at this age want to do things that really express themselves, in addition to dancing and singing. Does (child) ever like to color, paint, build things out of clay, or anything like that?

Mother: Yes, all of my children like to color and paint. He is also just getting into pasting. I keep a big box of paper scraps and about two months ago we started learning how to paste.

Visitor: How often does (child) do these things?

Mother: Well, he colors and plays with the play dough almost every day. He doesn't play with the clay as often. He seems to like the feel of the play dough better. But, I guess he probably plays with the clay 2-3 times a week. And then I get the paste and paper out about 2 times a week--whenever one of the children asks for it. I really get it and some scissors out once a week at a time when none of the kids have asked for it so that we can start learning how to use scissors--I make it into an art project. And that is in addition to the couple of times a week (Child) asks for the paste.

Visitor: Can (child) get the crayons & paper and play dough any time he wants it?

Mother: Yes, it is always kept out on the small table in the corner.

Item #5 - 2 or more toys or games requiring refined movements are available to the child. This item concerns toys which encourage fine motor development - those requiring a certain amount of control in their use. Credit small building materials (legos), train sets requiring assembly, dolls with clothes that can be put on and taken off, crayons & paper, scissors & paper, string beads, etc. These toys and games must be available to the child at all times. Puzzles should not be counted for this item since they are explicitly covered in Item #2.

Scoring Examples:

Example: Mother reports having legos, different types and sizes of beads to string, crayons, scissors and paper and paste. The legos, beads and crayons & paper are out and available to the child at all times - Score "yes".

Example: Mother reports having legos, beads to string and crayons, but they are all kept up because of the two younger children (twins) in the home. The mother reports that the toys are brought out several times a month, when the young children are napping - Score "No".

Interviewing and Probing Example:

Visitor: Children this age often try to do things that require finer control of their finger movements. Have you noticed (child) doing any of those things recently?

Mother: Well, I don't know.

Visitor: Does he ever like to build things with legos, color, string beads or anything that really makes him use his fingers?

Mother: Oh yes. He builds unbelievable things with the legos. And he can cut with the scissors better than any of the other children his age.

Visitor: Does (child) ever go and get any of these toys and things and just start playing with them on his own?

Mother: The legos are the first thing he goes to when he gets up in the morning. And he does get the crayons and color by himself, but that is only a few times a week. I keep the scissors up.

Visitor: How often do you find time to get the scissors out and let (Child) cut?

Mother: Two times a week for projects and just when he asks for them. I don't bring them out if I have to feed the baby, but any other time I do.

Item #6 - 2 or more toys or games which help teach numbers are available to the child. Items which would receive credit include puzzles with numbers, blocks, books, games, computer games, dominos, playing cards, etc. Books alone are not enough to credit. **Visitors may credit one book and one other toy or game.** Once again, the mother must help the child use these toys for this purpose. And they must be used at least once every two weeks for teaching numbers to receive credit. The mother does not have to take the sole responsibility for this task, credit may also be given if another adult in the home or an older child (13 years or older) performs the task.

Scoring Examples:

Example: Mother reports having 2 puzzles with numbers. The puzzles both have the same numbers in them - Score "No".

Example: Mother reports having one puzzle with numbers, dominos, 2 books with numbers (different books and ways of looking at numbers) and Sesame Street Counting Cards. Score "Yes".

Example: Mother reports having 2 books with numbers. The books are different and have different approaches to looking and learning about numbers. Score "No".

Example: Mother reports having a book with numbers and a puzzle with numbers. Score "Yes".

Interviewing and Probing Example:

Visitor: Does (child) know any of his numbers yet?

Mother: Yes, he is counting, or I guess I should say he is trying to count and say the words.

Visitor: How is he doing that?

Mother: What do you mean?

Visitor: I mean do you sit and count with him, do you play games with numbers, like dominos, puzzles, or do you have books with numbers?

Mother: Oh yes. We have books and puzzles with numbers. He likes for me to read the number book and guess which number that page is talking about. I think he really knows which number it is now from just looking at the figure. We spend a lot of time doing that. (You have just gotten an answer to item #36.)

Visitor: Does he play with any of the other toys or games you have?

Mother: Yes, he likes to play with the animal dominos. He will take the counting cards and then match the dominos to the numbers on the cards - or I should say he tries to. He does a good job really. He can match 1-5 correctly each time, but he still has trouble from 6-10. (You have just gotten one of the two you need to score "+" on item #30.)

Visitor: Oh, that sounds really exciting. I bet it is a lot of fun to see that. (Note that this is a very leading statement.)

Mother: Oh! It really is. (Child) come over here and show Miss Carol how you match your animals on the dominos to the counting cards. (You have just gotten enough information to score item #32.)

Item #7 - 10 or more children's books are available to the child. Note that these are children's books. They should be age appropriate or slightly above age level. The books may be shared - they do not have to be the sole property of the study child. They should be in reasonable readable condition.

Scoring Examples:

Example: A 15 page book with only 2 pages left (none of the books really have enough pages to use properly) - Score "No".

Example: Books that are dog eared with only a few small tears where pages are still readable and pictures can still be seen. Score "Yes".

Example: Stories on records and/or tapes do not receive credit on this item unless the target child is visually impaired.

Example: There are 2 golden books present and available and 8 plastic books (air filled bath safe for infants) and small hard page books present and available. No other books are available. There are 15 age appropriate books that are kept on the fifth shelf of the bookcase in the play area. These 15 books are brought down and held by the mother as she reads to the child. This is done only on special occasions. Score "No".

Example: There are approximately 15 Golden Book type books visible on the shelf next to the bottom of a bookcase in the children's playroom. Score "Yes".

Interviewing and Probing Example:

Visitor: I know how hectic it can get when you care for several young children. Does (child) ever want you to read to him or does he ever get still enough to look at books by himself?

Mother: Well, he likes for me to read to him, but he also likes to look at books himself. I have noticed, just in the past six months or so that he can sit for 10-15 minutes and really seem totally engrossed in books.

Visitor: Does he have a favorite book, or should I say books?

Mother: There are two books that he always looks at first, The Three Bears and Barney Goes to the Zoo. He always pulls those two books out when he wants to read or have me read to him.

Visitor: Does he ever look at other books?

Mother: Oh yes, but those are the first choice.

Visitor: About how many books do you have that are for children around his age?

Mother: Those two bottom shelves are all books that are for about the right age for the younger children.

Item #8 - 10 or more books for adults are visible in the home. The intent of this item is to determine whether the child is being cared for in an environment where reading and having books is valued. The key to this item is that the books are seen by the child as being of value to the mother. The books may be a set of encyclopedias, cookbooks, novels, etc. They do not have to belong to the mother - they may be library books. Professional journals and high quality magazines such as National Geographic may be counted, but each set may be counted as only **one book.** To be considered in this high quality category, a magazine must be of a reference nature. For example 3 issues of a professional journal would only count as one book, just as 15 issues of National Geographic would only count as one book. It does not matter how many magazines are in the set, the entire set would only count as one book. The important point is that there are 10 or more books and that the books are visible to the child.

If the books are kept in a room other than the areas where the child is normally cared for (upstairs in the study, etc.), then the child must be allowed to go into the room where the books are kept. The child does not have to go into that room if s/he chooses not to, but the child must be allowed to enter it whenever s/he wants in order to receive credit. If adult books are not visible, the visitor should ask about their presence and where they are kept. If the books are stored in a closet, in boxes or in sacks, credit should not be given.

Scoring Examples:

Example: Mother reports having books in her bedroom. The books are kept in the closet. The (Child) is allowed into her bedroom.. Score "No".

Example: Mother has 35 journals dealing with child development and 50 books. Score "Yes".

Example: Mother has 15 National Geographic magazines, 25 child development journals, 5 journals on safety and 5 books. Score "No". (3 collections of high quality magazines equals 3 books, plus 5 books equals 8 books.)

Example: Mother reports having at least 15 books in her bedroom. They are stored in the bookcase headboard of her bed. The child is allowed into the room. - Score "Yes".

Example: Mother reports trading books with friends. Most are kept in grocery sacks to keep them separated by owner. The sacks are stored in a hall closet. The child is not allowed to open or enter that closet. Score "No".

Example: Mother reports trading books with friends. Most are kept in grocery sacks to keep them separated by owner. The sacks are stored in a hall closet. The child is not allowed to open or enter that closet. The visitor notices 4 books on a table beside the desk/work area, 2 cookbooks on the counter by the kitchen sink and 6 books on child activities on the bookshelf two rows above the children's books in the den. Score "Yes".

Example: Mother reports the family has collections of Field and Stream, Readers' Digest, Scientific America, Playboy, Life, U.S. News and World Report, People, Soap Opera Digest, New York Review, and 6 books - Score "No".

Interview and Probe Example:

A good time to discuss this item (if it is necessary to do so) is when the visitor is talking about the number of available children's books (item #7 and about encouraging the child to read a few words (item #37).

Visitor: I know how busy you must be. Children this age can be pretty active. Do you ever find time to read yourself?

Mother: Not very much. I do read for pleasure in the evening before I go to bed, provided I have all the housework done. I do a lot of reading though when the kids are taking a nap (or should I say when they are lying down - I have two who do not sleep much). But it is not pleasure reading. I use that time to go through books for ideas for crafts and play activities.

Visitor: Do you have many of those kind of books?

Mother: I probably have about 6 books with different activities for children.

Visitor: I know you mentioned that you read for pleasure in the evenings, do you have your own books or do you go to the library?

Mother: I have books of my own, but I also go to the library about once a month.

Visitor: About how many books would you say you have, either of your own or counting your own books and library books?

Mother: Oh! That is hard to say. Probably around 50 of my own, and that is not counting all of my husband's woodworking books and my oldest son's painting books.

Visitor: That really sounds like a lot of books. Where do you keep them all.

Mother: I keep some down here, so that I can use them with the children activities. I guess there are probably 6 or 8 down here. And I keep 2 or 3 cookbooks down here and usually 1 or 2 novels just in case I get a chance to read a paragraph.

Visitor: Does (Child) ever get a chance to go into the other part of the house where your other books are kept.

Mother: Yes, he has the run of the house except for my oldest son's room. We also pass 2 bookcases on the way up the stairs to the bedroom.

Item #9 - Parent reads a newspaper daily in the home. This item is intended to determine the reading habits of the mother. The newspaper must be read daily (or 5 days a week if the paper is only available M-F), and in the presence of the child at least once each week. The paper does not have to be read in its entirety, but it does require more than looking at the comics and the TV section. The paper can be a Sunday-Saturday edition, but credit may also be given for Monday-Friday papers. Visitors should remember that the child needs to see the mother reading the paper at least once a week for credit to be given.

Scoring Examples:

Example: Mother reports reading the paper before the child gets up in the morning. Score "No".

Example: Mother reports reading the paper in the evening after the child is in bed. Score "No".

Example: Mother reports reading some of the paper (she tries to read the front page) while the children are watching Barney on TV. Score "Yes".

Example: Mother reports reading as much of the paper as she can when the children go down for rest and nap time and they do not see her reading. Mother also reports that (child) sees her reading the remainder of the newspaper in the evening before going to bed - Score "Yes".

Example: Mother does not get (neither buys nor is given) a paper. Score "No".

Interviewing and Probing Example:

Note: Visitors will find this item is easily discussed along with item #10.

Example 1:

Visitor: I know how busy you must be caring for your children. Do you ever have time to read for your self?

Mother: Not while the children are here. I am just too busy looking after them to find time to read the paper

Example 2:

Visitor: I know how busy you must be caring for your children. Do you ever have time to read for yourself?

Mother: Yes, I try to read when the children go down for a nap.

Visitor: What kind of things do you like to read when you get that chance?

Mother: I usually only have time to read the front page of the newspaper. And occasionally, if they are tired, I actually get to read the entire front section.

Visitor: Is (child) asleep when you start reading the paper or does he see you reading before he drifts off?

Mother: He takes about 5-10 minutes to fall asleep. But I don't know if he is watching me read or not. He insists on napping on the sofa here in the den so I am in clear view, but I have never asked if he has seen me read it or not. (Score "yes" in a situation such as this.)

Item #10 - Parent regularly buys or receives 1 or more magazines. Any magazines would be credited on this item, including children's magazines. The content of the magazine is not important for this item. The mother must subscribe, buy regularly or be given magazines regularly to receive credit on this item. The intent is that the mother has access to consecutive issues of the same magazine at more or less regular intervals. Regularity of magazine acquisition is what is at issue rather than whether she subscribes, buys or receives magazines from someone. The Star, National Enquirer, etc. may be counted as magazines.

Scoring Examples:

Example: Mother reports subscribing to Sesame Street - Score "Yes".

Example: Mother reports buying Ebony every month at the grocery store. Score "Yes".

Example: Mother reports she does not subscribe or buy magazines because her mother has a beauty shop and she brings over all she has in the shop when the next month's issues come in. Score "Yes".

Example: Mother buys the National Enquirer every 3-4 months when she can afford it. Score "No".

Example: Mother buys The New Yorker about every other month. Score "No".

Interviewing and Probing Example:

Note: This item can be discussed when the visitor is talking about items #8 and #9.

Introduction Example: 1

Visitor: I'm sure it must be hard for you to find the time to read when you have children to watch. Do you ever get a chance to read?

Introduction Example 2:

Visitor: I know you told me you try to read the newspaper and you have books you read in the evening. Do you like to read magazines?

Mother: Yes, I don't have much time, but I do like to keep up with some of the newer ideas that come out.

Visitor: What magazines do you like?

Mother: I like Woman's Day, Family Circle, Good Housekeeping, and Redbook.

Visitor: Oh! Do you get all of those each month?

Mother: I buy Woman's Day and Family Circle each month at the grocery store. But I get the others less regularly.

Item #11 - Child is encouraged to learn shapes. (This item is easily discussed when the visitor is talking about the items in the Academic Stimulation Subscale #33-37.) For this item to receive credit, the mother must make a conscious effort to help the child recognize different shapes and their names. Someone else in the home may perform this task--an adult or even an older child (13 years or older).

Scoring Examples:

Example: Mother reports that she holds up different shapes and tells the child the name of each and asks him to repeat it. Score "Yes".

Example: Mother reports that she draws different shapes and labels them for the child. Score "Yes".

Example: Mother reports that she has started working on such things as "the ball is round", "the box is square", etc.. Score "Yes".

Example: Mother reports that she does not have the time, but one of her teenagers does this after school - Score "Yes".

Example: Mother reports that she really has not done anything herself because Sesame Street, Electric Company and Barney teach shapes on their shows. Score "No".

Interviewing and Probing Example:

Visitor: Tell me, does (child) know any shapes and their names?

Mother: He knows round and square and can usually show you something if you ask him. (Child) come here. Show Miss Smith something that is round, you know a circle, like a ball. (Note that this mother has just given you information to score item #32.)

Visitor: How did he learn to do that?

Mother: Well, I really noticed him picking up some things as he watched Sesame Street. When that happened, I started working with him by pointing out the round and square objects around the room and talking about them.

Visitor: How long has (child) been able to point out these things?

Mother: About 3 months.

Language Stimulation

Item #12 - 2 or more toys that help teach the names of animals are available to the child. There should be two or more toys (in usable condition) present in the home at the time of the visit. Toys which would receive credit include: stuffed animals, toy (plastic or wooden) animals, books about animals, circus games, farm sets, and animal puzzles. The mother must use these toys to encourage language development through conversation, modeling and direct teaching. The mother does not have to take the sole responsibility for this task, credit may also be given if another adult in the home or an older child (13 years or older) performs the task.

Scoring Examples:

Example: Mother reports that there are several different stuffed animals, a farm set, and two books about animals. She also reports that she teaches the study child the names of these when he gets a stuffed toy off of the shelf and when they look at the books - Score "Yes".

Example: Mother reports that there are 3 teddy bears and, for the most part, the child learns the names of animals from walks in the neighborhood. She reports the child knows the names of dog, cat, bird and bear - Score "No".

Example: Mother reports that she has a farm set and two books of animals, one on zoo animals and one on household pets She says that she uses all of the toys in a direct teaching method and that the study child knows all of the names of the toy animals she has in the home.- Score "Yes".

Example: Mother reports that she has a farm set, extra plastic farm animals (because the older children want to play with them at the same time), animal puzzles, 6 different stuffed animals (a bear, a dog, a cat, a pony, a monkey and a lamb), 4 animal books and a household pet bird. She reports that, other than the pet bird and one of the stuffed animals, all of the toys are kept up so the baby will not choke on any of the pieces. The books are kept up so the pages won't get torn. These toys are brought out a few times a week when the baby is taking a nap. The mother reports that she doesn't do anything to help the child learn the names of these animals. He picks up the names from the other children in the neighborhood. Score "No".

Interviewing and Probing Example:

Visitor: I noticed (child) playing with the little farm animals you have. Is that one of his favorite pastimes?

Mother: Yes, he is fascinated with the horses. I believe he will be a cattle man or cowboy when he grows up.

Visitor: Well, if he is a cattleman, he may make a lot of money. I'm sure you and your husband would be happy with that. Does he play with any of the other toys you have that are animals?

Mother: Yes, he plays with them all. He seems to like the zoo book and he works 3 of the puzzles all by himself - the pony puzzle, the jungle puzzle and the kitten puzzle. But his favorite is the farm set.

Visitor: Does he know the names of all or most of those animals - besides horse?

Mother: Oh yes. He has learned the names of almost any animal you can think of from watching the children's shows.

Visitor: Do you, or did you, help (child) with any of the animal names?

Mother: No, I just let him watch TV and the videos.

Visitor: Do you ever have to remind (child) of the name of an animal, such as when you tell him to go get the stuffed bear or when you are looking at a book?

Mother: Oh yeah, I do that kind of thing. I thought you meant some real formal teaching thing. I often remind him of what one of the toys is called and also help him by describing one when he seems to have forgotten what a certain animal is. But I don't do any sit down teaching about animals.

Item #13 - Child is encouraged to learn the alphabet. In determining the score for this item, any attempt to introduce the child to letters is acceptable for credit. The mother does not have to be responsible for performing this activity alone. Any adult in the home and/or an older child (13 years or older) may perform the task of helping the child. Activities which would be credited include: teaching the child to print her name; talking about and pointing out letters (in books, magazines, on flash cards, on blocks, etc.); playing with a chalk board; using computer games that deal with letters and/or the alphabet; and singing alphabet songs.

Scoring Examples:

Example: Mother reports that her two teenagers teach letters to the study child when they come in from school - Score "Yes".

Example: Mother reports that she has several tapes that focus on the alphabet and what some of the letters stand for in song version. She reports they (the child's siblings) all sing as a group project and then talk about some of the pictures on the wall and what letters they start with. Score "Yes".

Example: Mother reports that the child's grandparents (living outside the home) have taught her all of her letters and she really does not have time to do anything like that because of the number of kids she has (three months ago this mother had triplets). The mother reports that it takes almost all of her time changing diapers and feeding the little ones and she does not have time to spend with the two older children - besides, they play so well together, she seldom has to do anything with them. Score "No".

Example: Mother reports that she just turns on the TV and (Child) has been picking up some letters from the commercials and some of the children's shows - Score "No".

Visitors will probably want to discuss this item when talking about the items (33-37) in the Academic Stimulation Subscale. The example below will include an introduction to a discussion of all of these. Each of these items can be interviewed and probed, separately, using the same formula.

Interviewing and Probing Example:

Visitor: Tell me, does (child) know any of her letters, numbers, colors, directions such as up, down, under?

Mother: Let me see. She knows red, blue, purple and orange real well. And she can sing the ABC song. She completely understands "in", "on", "under" and she is getting better at understanding when things are "behind" something.

Visitor: Oh, that sounds exciting. How did she learn these things? Note that the visitor's expression of excitement is somewhat leading. It would be better to just ask how she learned to do those things.

Mother: Well, the letters we learned mostly from singing songs. And the colors we learned while she was coloring and I kept reinforcing them just talking about different toys, like those we talked about before, and just pointing things out.

Visitor: That sounds like fun. Was it hard to teach the ABC song? Or does (child) like to sing anything?

Mother: Oh, she likes to sing anything, but all of my kids seemed to really enjoy the ABC song. I think they mainly liked the melody, but they also got excited when someone told them they know how to say the ABC's. We have now started (Child) trying to just say them without singing.

Visitor: That sounds like she is really learning a lot. Is she that good with numbers?

Mother: I guess you would say so. She can count up to 6 with no mistakes, but she has trouble after that.

Visitor: It sounds like you do some work on numbers during the day here. What do you do?

Mother: We started by just rote counting and then having her do it on her own. Now I have started letting her look at the actual figure and then labeling it.

Visitor: That sounds like she is actually reading the numbers. Is she trying to read anything such as her name or other short words?

Mother: Well she is not really reading. I have only tried to teach all of my kids to find their own names on chairs, papers, etc. I do have some pictures that I have pasted labels on such as "cup", "door" and so forth.

Visitor It sounds like you have a really good time here. Tell me how in the world did you teach (child) up and down, under and on top of? That just fascinates me.

Mother: Oh! That is probably the most fun thing we do. I remember from my older children how easy it was. They mainly learned by my telling them to put their toys "in" the box and so forth. I do that with (Child) also, but, since I knew how easily they picked it up, I developed a game where we put on some music and have a kind of follow-the-leader game of putting our hand "behind" our backs, putting one foot "in front of" the other, etc.

Item #14 - Parent teaches child simple verbal manners (please, thank you, I'm sorry). In determining the score for this item, visitors must consider not only the verbal manners the mother teaches the child, but also the rules and explanations she uses in this teaching process. It is not enough for the mother to tell the child to use "please", "thank you" and other forms of verbal politeness, she must also explain why it should be done. This does not have to occur each time, but it does need to occur often enough for the child to learn why the manner should be used and then the explanation should occur often enough thereafter to reinforce that knowledge. A mother giving the command to say "Yes, ma'am" is really more in the realm of establishing the mother's superior status - not in explaining why such behavior is valuable. Credit should not be given to mothers who command a child to "say something" and then follow a refusal with punishment. Most attempts to teach manners are acceptable for crediting this item. There should be instruction in several (3 or more) forms of courtesy or politeness for credit to be given for this item. The mother does not have to take the sole responsibility for this task, credit may also be given if another adult in the home or an older child (13 years or older) performs the task. It is also not critical that the mother give the same explanation for manners that one finds in a book on etiquette, so long as it deals with matters of courtesy or respect or social responsibility.

Scoring Examples:

Example: Mother reports that (child) has been saying "please" and "thank you" each time she tells her to do so. The mother reports that she simply says "say thank you" and makes (child) say please before getting her what she asks for. Score "No".

Example: Mother reports that they have a time each day where they discuss certain things that make "nice boys and girls". They talk about when to say please and thank you. And they also talk about what to say when they hurt someone's feelings. The mother also reports that she and (child) then choose a manner for the week and use it whenever appropriate. Everyone in the family reminds each other when it should be used. Score "Yes".

Example: Mother reports that manners are one thing all her children will use. If they don't say thank you, they are sent to time out - Score "No'.

Example: Mother reports that she had really not worked on this until the last 3 months when a neighbor discussed what they were doing at home with their child. I thought it was a good idea and have been trying to work on the basics such as please, thank you, and I'm sorry. It is really easier than I had thought it would be. All you have to do is supply the word when appropriate and in just a little while (Child) is using it. Sometimes she uses "thank you "at the wrong times, but she will eventually figure it out - Score "No", because the mother did not explain why.

Visitors may actually see this occur during the 2 hour portion devoted to data collection for the H.O.M.E. If the teaching does occur, and it occurs with explanations, visitors may credit the item without discussing it with the mother. If it is not clear that this teaching occurs on a regular basis, discuss the item.

Interviewing and Probing Example:

Visitor: Sometimes, around this age, children begin to use simple polite phrases such as "please" and "thank you". Has (child) started using anything like that yet?

Mother: Yes, she was saying "please" when she was 2 1/2.

Visitor: So that was something she picked up here at home you think?

Mother: Yes.

Visitor: Does (child) use any other phrases like that?

Mother: Sometimes she will say "tank you". I get a kick out of hearing her say it that way. "Please" comes out "peas". It is really cute.

Visitor: Does she say anything else besides "please" and "thank you"?

Mother: Sometimes, lately, I have heard her say "I tarry".

Visitor: How do you think she learned to say "thank you" and "I'm sorry"? Did you work with her on them, help her practice or any thing?

Mother: No, she has picked it all up from TV..

Item #15 - Mother uses correct grammar and pronunciation. In order to receive credit for this item, the mother must be able to communicate in such a manner and with enough precision that she can be understood by the visitor. Being able to be understood is more important than the ability to use "The King's English". Dialectical differences do not result in a negative score, provided the mother can be understood. Severe speech problems (e.g. stuttering, major difficulties with articulation, pronounced voice disorders, etc.) would, however. The key to this item is the mother's ability to communicate clearly and precisely.

Scoring Examples:

Example: Mother speaks in a voice that is loud enough to be heard above the noise of the children present. On several occasions she uses ain't instead of isn't and "they come" instead of "they came". Score "Yes".

Example: Mother speaks in a very soft voice which can barely be heard. The visitor has to ask her to repeat several things that are said in order to hear. The words that are spoken can be understood once the visitor hears them. Score "Yes".

Example: Mother stutters so badly that some of the intent of what she is saying is lost by the time all of the words are out. Much of the sentence is not completed, due to the stuttering and the visitor must guess at some of the verbs that were missed. Score "No".

Example: Mother has a hard time in telling the visitor what she wants to say. When asked a question, she mumbles and uses a lot of "oh, I don't knows". The mother does use fairly good grammar when she gets an entire sentence out, but most of her conversation is disjointed and she jumps from one thought to another, speaking as she thinks. Score "No".

Example: Mother is from a foreign country. She is still having trouble with noun and verb agreement, yet the visitor can understand what she is saying. The mother is very expressive and uses gestures to help with the meaning of what she is saying. The visitor and the child can clearly understand her with no misunderstandings. Score "Yes".

Interviewing and Probing Example:

Visitor: This item is scored on observation alone.

Item #16 - Parent encourages child to talk and takes time to listen. The key to this item is that the mother encourages the child to talk. She must do more than simply listen to the child. There must be a conscious effort on her part to inquire about the child's activities and then listen as the child relates them. The mother does not have to take the sole responsibility for this task, credit may also be given if another adult in the home or an older child (13 years or older) performs the task. The visitor may see this occur. If it happens only once during the visit, the visitor should discuss the item with the mother before determining a score.

Scoring Examples:

Example: Mother asks (Child) as she comes in from playing what they did and listens to what she says. Score "Yes".

Example: Mother asks (child) what she did when she went to the mall with grandma last night. The child begins a lively story of going to visit the Easter Bunny at the mall. During the story, the mother walks off to turn on the TV and sits down with two other children. Score "No".

Example: Mother reports that they have circle time as a family and each child has time to talk about whatever s/he wants. It may be what they did during the day, what they are going to do tomorrow, something they have seen, etc. The other children as well as the mother all listen to what (child) says. Score "Yes".

Example: Mother reports that she spends some time with each child when she comes in from work. The mother reports that she has found it most helpful to get the children to tell her about something they did while they were in school/day care.. She says she has a smoother transition as well as some interesting stories to bring up later for family group time. Score "Yes".

Example: Mother reports that she is so busy she rarely has time to listen to (Child). Besides, she gets real tired, real fast, listening to that little mouth going all day. Score "No".

Interviewing and Probing Example:

Visitor: I have noticed that a lot of children about (child's) age have started getting excited about what they are doing or have done or plan to do. Does (child) ever come in telling you about her activities?

Mother: Yes, she has developed into quite the little chatterbox over the past few months. Her father is in the military and was overseas for several months. Since he came home a few months ago, she has come in every evening with something they are going to do together. She even had him go for show and tell. All of the kids were excited to see his uniform.

Visitor: It sounds like she has a lot to say and it sounds like you listen to what she is telling you. How do you ever find the time to listen to her and your other children and do everything you have to do?

Mother: Oh, I just take the time. I think it is important for children to have a chance to share their experiences and to be heard. I start worrying if one comes in and doesn't have any special happenings to relate. That usually only happens when they are sick or getting sick.

Visitor: So it sounds like she is always ready to start talking. Do you ever have to ask her if she did anything special the night before?

Mother: I did when she first started talking. But now about all I have to do is ask her about something she did in day care (I usually know if she is going to do something real special) and then we have a big conversation about it.

Visitor: Do you find that you have to inquire about her play activities during the day to start a conversation?

Mother: I do that more for what she is doing here during the day than I need to do when she comes in the evenings. She gets involved in an activity. Sometimes, if it is something like an art or craft project, I will wait until she has finished, because she becomes so engrossed in what she is doing that I hate to break her concentration. But once she has finished, I always ask her what she has made, brag on it, and ask her why she used a certain color. She seems be getting better lately about just coming over and telling me what she has done.

Visitor: That sounds exciting. I know it must be fun to hear about the things that are important to (child).

Mother: Yes. I feel it is really important to listen to them. And I feel it is important that I really get them started in initiating conversations, because I feel that will help them be more independent and self-assured later in life.

Item #17 - Mother's voice conveys positive feelings about child. For this item, the visitor should listen to the mother's tone of voice when she talks about the child, as well as to what the mother says. Visitors should look for the mother being pleased with the child, proud of the child, happy to have the child around, talking about the child in a pleasant way, talking about the child in a joyful manner, etc. Visitors should not automatically score this item "no" just because the mother mentions or explains the child's limitations. There is a difference in explaining limits as opposed to dwelling on the "bad" traits the child possesses.

Scoring Examples:

Example: Mother says she has really enjoyed having (child).. She is always happy and joyful. Score "Yes".

Example: Mother says she has had nothing but trouble with (child) and, since she is now three, she has really led the other children into things they never got into before. Score "No".

Example: Mother says that (child) has been having trouble with learning how to play and share toys with other children when they come over to play. The mother says (child) seems not to be upset when the rules of sharing and playing together are explained and that she goes off to another activity in a happy mood. Score "Yes".

Example: Mother says that (child) has terrible temper tantrums that are practically uncontrollable. The mother also says that she is seriously considering asking the grandmother to take (Child), because she just cannot handle the hitting, biting, constant crying and most importantly, she does not like the idea that this child has "ruined her happy home". Score "No".

Interviewing and Probing Example:

This item is scored from observation alone.

Item #18 - Child is permitted choice in menu for meal or snack. The key to this item is that the child's wishes receive some consideration. The mother does not have to offer or grant a choice at each meal or snack, but some choice on some type of schedule or regular basis should be offered. It may be that each day the child if offered a choice of two different things to eat for lunch. That would receive credit. It may be there is no choice at lunch, but a choice of two different fruits at snack time. That would also receive credit. The choice does not have to be offered on a daily basis. It may be offered weekly, such as each child in the family choosing a food for a snack or lunch, with each child having a turn. But there must be some choice permitted and it must not be on a random basis. There must be some type of regularity for that choice.

Scoring Examples:

Example: Mother reports that every Friday the children make a group decision on what to have for lunch. Score "No".

Example: Mother reports that every Friday one child (on a rotating basis where each child has a turn) chooses what to have for lunch and snack that day. Score "Yes".

Example: Mother reports that she does not let the children choose either a snack or lunch menu because they would eat nothing but junk all the time. Score "No".

Example: Mother reports that, on most days, she has two things she can fix for lunch and that she asks each child which s/he wants to eat. Once in a while she will buy special treats for the children, but there is usually no choice, except the two things she buys once she has been to the store. The mother always asks the children if they want her to buy this cookie or that cracker for snacks when she goes to the store, but she always gives them a choice of what she thinks is appropriate. Score "Yes".

Interviewing and Probing Example:

Visitor: Children this age can sometimes get real picky when it comes to eating. How does (child) do in that area?

Mother: She does real well. She will eat almost anything you put in front of her.

Visitor: Does (child) ever ask for any certain food, like at lunch or for a snack?

Mother: She will always ask for a drink of water when she is thirsty, but that is about it.

Visitor: Do any of the other children make requests?

Mother: Yes, I have two who have real favorite foods and are much pickier eaters than (child).

Visitor: It must be hard when they all want something different. How do you deal with that or what do you say to them?

Mother: Well, almost every day I have two things for lunch and I ask each which they want. I pretty well know their likes and dislikes now, so I stick fairly close to those things - within the bounds of reasonably good nutrition. If they keep insisting, I just tell them that I will get some when I go to the store this weekend and we will have it next week.

Item #19 - Building appears safe and free from hazards. Visitors should remember not to use definitions from any instrument other than the Early Childhood H.O.M.E. to determine how to credit this item. In this item, visitors should concentrate on the safety of the building. Things to look for include: plaster coming down from the ceiling; boards missing on stairways; no handrails on stairs; no backboards on stairs; exposed insect or animal traps; raised fireplace hearths; frayed electrical cords; open gas fires; metal space heaters; household cleaners (such as bleach, cleaning fluids, poisons) within easy reach of the child; insects and or rodents running around in the building; lack of screens on upper story homes; frayed electrical cords; etc. In scoring this item visitors should be concerned with structural hazards as well as the objects which might cause injury. Neither overcrowding nor clutter in the home count as hazards (unless either or both are to such an extent that injury could occur as a result). Visitors should look for the "accidents that are just waiting to happen".

Scoring Examples:

Example: Visitor notices no backboards on the stairs. The stairs are leading from the upstairs where the kitchen is located and the children eat, to the den downstairs where the children play. The children must use these stairs daily. Score "No".

Example: Visitor notices four stacks of cardboard boxes in the corner of the den where the children play. They contain books. The boxes are stacked within four inches of an open metal gas stove. Score "No".

Example: Visitor notices a deck outside the den, where the children play. The mother reports that the children play outside on the deck and in the yard beyond. The deck is 4 feet off the ground on the side without the stairs and 5 feet off the ground on the end with the stairs. The railing around the deck is made up of a board at the top and one midway down to the flooring. There is approximately 3 1/2 feet of space between the flooring and the first rail. Score "No".

Example: Visitor notices a set of sharp knives in the kitchen in a rack which is attached to the end of an above counter cabinet. There are no chairs or stools in the kitchen and the children are not allowed in the room. They eat in the dinning room. Score "Yes".

Example: Visitor sees a rat scurry from behind a pile of fireplace wood. Score "No".

Example: Visitor steps inside the door to the home and, as she does, she feels the floor give under her foot as if the boards were about to fall or break. Score "No".

Example: Visitor sees the mother's husband come into the den, where the child is playing, and put his paint thinner on the table. He leaves the room several times for one reason or another, leaving the paint thinner on the table. Score "No'.

Example: Visitor sees the grandfather's hunting equipment (gun, knife in its sheath, and ammo vest) lying in the corner of the den. Score "No".

Interviewing and Probing Example:

This item is scored on observation alone.

Item #20 - Outside play environment appears safe. In order to accurately assess this item, the visitor must first determine where the child plays when outside. The outside play area does not need to be adjacent to the home, but it should be within a very short walking distance, such as a block or two. If there is no outside play area available, score "no". The visitor should use good judgment when scoring this item. Once again the key is to look for accidents waiting to happen. Things to look for include: broken glass; rusty metal lying around; junk cars and/or piles of debris in the yard or along the side of the street; open ditches or a house so close to the street a child could not safely play in the yard; boards with nails sticking out of them; drug paraphernalia thrown into the yard or the side of the street next to the house; broken or unsafe play equipment; limbs of trees that are rotten and ready to fall; piles of lumber or firewood that could harbor snakes, etc. Visitors should look for all of these things on the path the mother and child walk if the outside play area is in a park a block or two from the home. It is wise to walk or drive that route after the visit to accurately assess the situation.

Scoring Examples:

Example: Visitor notices a broken bar on the metal swing set. It is sticking out at such an angle that a child running could easily suffer severe injuries to the head and neck area if the bar were hit. Score "No".

Example: Visitor notices a pile of firewood that is about 4 feet high. In some areas of the country that is a good place for spiders and snakes (including poisonous varieties) to nest. The children are allowed to play in the area and even on the logs. Score "No".

Example: Visitor is told that the children have to go 2 blocks to the park to play. After the visit, she drives the route to the park. She notices drug users on the sidewalk and even sees used syringes at the curb. Score "No".

Example: Visitor is told the children play in a common yard area in back of the apartment building. They use the same stairway the visitor used coming into the building. The visitor noted that, although the stairs appeared to be sound, the handrail was so wobbly she was afraid it would not be strong enough to break her fall, let alone stop it. Score "No".

Interviewing and Probing Example:

This item is scored by observation alone, once the visitor has determined the play area and the route taken to get to it.

Item #21 - Interior of the home is not dark or perceptually monotonous. Visitors must use their judgment in scoring this item. They must not, however, base scoring on a completely middle class sense of style. Visitors should, rather, look for efforts to liven up, lighten up, and generally make a home more attractive. Things to look for include: good lighting, open drapes, pictures (these may even be something cut from a magazine and unframed) or plants (may be artificial); children's art work displayed; learning materials on the wall and tables (ABCs, bulletin boards, posters). Very little furniture and everything in the room of the same general color would receive a score of "no." Almost any effort to make the home attractive would receive credit. Observations should be based on the rooms the child is allowed to enter.

Scoring Examples:

Example: Visitor sees no pictures, posters or wall decorations of any kind in either of the 2 rooms in which she is allowed to enter. Score "No".

Example: Visitor notes that the home appears to be very poor, yet the mother has the curtains open, lamps lighted because of the cloudy weather, and has even put up two pictures that appear to have been cut from a magazine. The pictures are hung unframed. Score "Yes".

Example: Visitor has trouble seeing her forms because there are no lamps on and all of the curtains are closed except one. Score "No".

Example: Visitor notes that, although, the walls are painted in a beige color which closely matches the furniture (even the wooden children's furniture), the mother has hung posters, ABC charts, has made sort of displays of some of the children's books, and even arranged the stuffed animals in an interesting display. Score "Yes".

Interviewing and Probing Example:

This item is scored on observation alone.

Item #22 - Neighborhood is aesthetically pleasing. In this item the visitor is looking for general pride in the neighborhood. The area may be in one of the poorer sections of town, where the houses are old, but if the residents have maintained the homes in reasonable condition and kept the yards clean, credit can be given. Garish, unsightly and /or dilapidated housing would receive a "no" score. Visitors should look for the following things: trees; grass; mowed lawns; clean sidewalks; no boarded-up buildings; no junked cars; no drug addicts loitering across the street; debris and garbage cans not present (except on trash pick-up day); abandoned buildings, etc. It is not absolutely necessary that the neighborhood have grass and trees, but is essential that efforts have been made to keep the area clean and pleasant to view.

Scoring Examples:

Example: Visitor notices the house across the street has big pieces of paint peeling from it and two old rusty cars sitting in the yard between the house and the neighbor's fence. Score "No".

Example: Visitor notices all the homes seem to be in good repair and the whole block seems to have flowers blooming. Score "Yes".

Example: Visitor notices that all homes appear to be in good repair, the yards have trees and grass and shrubs, but two houses down and across the street, there is an abandoned building which has been boarded up and the yard has not been cut for several months. Score "No".

Example: Visitor notices that all the homes in the area are older, but have no peeling paint. It is winter and there is no green grass to be seen, but there are leafless trees and it appears that the yards are kept up. Score "Yes".

Interviewing and Probing Example:

This item is scored from observation alone.

Item #23 - Home has 100 square feet of living space per person. In determining the scoring on this item, the visitor may use the simple rule of thumb of a 10 x 10 or 9 x 12 room as being about 100 square feet. Although this is an observation item, it may be necessary to ask the mother how many rooms are in the home and how many people are currently living there. (Note that visitors may want to wait until the family demographics in the structured interview to determine whether or not it is necessary to probe on this item.).

Scoring Examples:

Example: Visitor notes that the there are seven people living in a two bedroom apartment which has one bathroom and a combined living and eating area. No room appears to be bigger than the combined eating/living area which is approximately 12 x 12. Score "No".

Example: Visitor notes that (child) is the only child in the home with her mother and father. The house has 9 rooms all of which are at least 12 x 15. Score "Yes".

Example: Visitor notes there are 7 children in this home, an aunt, 2 grandparents and 2 cousins. The house has 10 rooms (counting the bathroom), but all are small, approximately 10 x 10. Score "No".

Example: Visitor notes that there are three children and two parents in this home. There home has 3 bedrooms (8 x 10), a den (12 x 15), a living room/dining room combination (15 x 20) and a kitchen (6 x 15). Score "Yes".

Interviewing and Probing Example:

This item is scored by observation alone.

Item #24 - Rooms used are not overcrowded with furniture.

Visitors should determine if the furniture is arranged in such a manner that there is room for the child to play and that exits are not blocked. Again, the visitor's sense of style is not what is at issue here. What is important is that rooms are not so crowded with furniture that children cannot engage in reasonable amounts of play and get in and out of doorways without stepping around or over or having to move furniture. Too much crowding increases the likelihood of injury and reduces the amount of exploration.

Scoring Examples:

Example: Visitor notices that there is a large area in the den for play. The children's tables and chairs are moved to one end of the room, forming a classroom effect. Adult furniture is sparse and moved to the walls in the room allowing a play area for the children in the center. Score "Yes".

Example: Visitor notices that all furniture has been moved to the walls forming a play area in the center of the living room. The sofa covers the door to the back yard. Score "No".

Example: Visitor notices the only adult furniture is one sofa, one chair and one rocking chair. All other furniture is child sized and it is in one end of the room, in front of the window. The rocking chair is over by the baby bed and the straight chair is placed at the counter separating the living area from the kitchen. All doors are free of furniture . Score "Yes".

Example: Visitor notes that in a 12 x 15 room there are two adult sofas, three arm chairs, two children's tables with four chairs each, a big screen TV, three end tables and one coffee table, a baby crib and three children's riding vehicles and an indoor gym.. Score "No".

Interviewing and Probing Example:

This item is scored by observation alone.

Item #25 - Home is reasonably clean and minimally cluttered. For scoring on this item, visitors will have to use their good judgment. Hospital clean is not the standard to use in making a decision. It is perfectly acceptable for toys and materials to be scattered around the play area. If a meal has just been completed and there are dirty dishes not yet washed, credit should be given. However, clearly unsanitary conditions would receive "no" scores. They would include such things as: roaches, ants, rats/mice, food on the floor (not just that the children have just spilled, but rather food that has been there for a few days/weeks), stacks of dirty dishes (again not just those that have been placed there to hold until you leave and they can be dealt with), sacks of old garbage sitting around, clothes or newspapers strewn across the floor or left piled in a corner, noticeable odors of urine/feces, etc.

Scoring Examples:

Example: Visitor must brush roaches off her papers before she can mark answers. Score "No".

Example: Visitor notices the strong odor of feces. She is informed that one of the children has diarrhea. The odor is coming from a plastic trash bag sitting in the kitchen. It is so full no other trash could possibly be put in it. Score "No".

Example: Visitor enters the home just as the children in the family have finished lunch. One child remains finishing her meal. Two items on the menu were green peas and something with raisins - most of which have landed on the floor. Score "Yes".

Example: Visitor enters the home to the unmistakable smell of a child having just vomited. There is an area on the floor with several paper towels over it. The mother is comforting a child, wiping her mouth, etc. She asks the visitor to come in and make herself at home - there has been a small emergency and she will be with her just as soon as she can get things under control. Score "Yes".

Interviewing and Probing Example:

This item is scored by observation alone.

Responsivity

Item #26 - Parent holds child close 10-15 minutes per day. For this item the visitor may credit the mother holding the child while she is involved in another activity such as watching TV or reading a book. The 10-15 minute period does not have to be done in one setting, it may be broken up into smaller portions of time throughout the day. The key is that the mother does spend that much total time holding the child and it should be in a more cuddling fashion, rather than in a "pick them up to keep them out of the way" manner. The mother does not have to take the sole responsibility for this task, credit may also be given if another adult in the home or an older child (13 years or older) performs the task.

Scoring Examples:

Example: Mother reports that (child) is not much of a cuddler, but does like to be held before napping. She reports that she does not have time to do that because she must rock the baby to sleep. Since that is the only time (child) wants to be held, she does not get held. Score "No".

Example: Mother reports that all her children want to be held and rocked. She cannot rock all of them at the same time, but she does take a period in the morning and then again in the afternoon and give each child turns rocking them for 5-10 minutes while the others are involved in their own activities and play. Score "Yes".

Example: Mother reports that, since (child) is an only child, there is plenty of time for holding her. She reports holding (Child) several times a day for a total of approximately one and one half hours. Score "Yes".

Example: Mother reports that she just simply does not have time to hold her younger kids. That is what makes sissies out of them anyway. Score "No".

Lead-in Examples:

Visitor: Even though children are pretty active at this age, sometimes they still want to be held. Does (Child) ever want you to hold her?

Visitor: It looks like (Child) goes ninety miles an hour all the time. Does he ever slow down? When he does, does he ever want you to hold him? Do you get a chance to hold him? About how long will he let you hold him?

Visitor: I see you have twins who are infants here. How do you manage things when all of the children want to be held and cuddled?

Item #27 - Mother converses with child 2 or more times during visit. To receive credit for this item, the mother must make an effort to converse with the child. Conversing would include such things as asking questions and talking about anything of interest - in other words the mother must engage in a verbal interchange with the child. It may be initiated by either, but it must be more than vocalizations, brief directions, rhetorical questions, commands, scoldings and/or accusatory comments.

Scoring Examples:

Example: Mother asks (child) if she enjoyed going to church last night. The child replies that she did. The mother then asks what (Child) did while in the nursery. The conversation continues with what songs they sang, if (child) stayed awake the whole time, how the other children liked the dress she wore, etc. The visitor notes this type of situation happening 4 times during a two hour period. Score "Yes".

Example: Mother is trying to talk to the visitor during a good portion of the visit. During this time the child is asking a great many questions. The mother occasionally mumbles an "uh huh". Throughout the allotted time frame, the mother never once has any type of give and take conversation with the child. Score "No".

Example: Mother asks (child) about her art project as she is doing it and later when it is completed. The mother discusses with the child what she might want to do after her nap. The mother is approached by the child and they have a conversation about the dog outdoors. The mother has a give and take discussion with the child concerning what she and her grandparents will do that weekend. Score "Yes".

Example: Mother and child have one give and take conversation. The rest of the time the mother merely answers questions very briefly or gives directions. Score "No".

Lead-in Example:

This item is scored from observation alone.

Item #28 - Mother answers child's questions or requests verbally. In order to receive credit for this item the mother must make an effort to answer most of the questions asked by the child. If the mother is unable to answer at that particular moment, she may tell the child they will talk about it later (look it up later, find out later, etc.). Any response which puts the child off (doesn't answer the question) with no promise of answering later would not receive credit. Examples would include: "Sh-h! I'm talking now.", "I'm busy now, go away.", "Don't bother me now.", etc. If the child makes no verbal request and asks no questions during the data collection time, score "No".

Scoring Examples:

Example: Mother answered each question asked by the child. Score "Yes".

Example: Mother answered less than one half the questions asked by the child. Score "No".

Example: Mother responded to most of the child's questions by remarks which were "No, you don't.", "No, you can't.", and "What did I tell you?". Score "No'.

Example: Child did not ask any questions. Score "No".

Example: Child did not ask any questions, but he did make three requests while there. The mother responded verbally to each request. Score "Yes".

Lead-in Example:

This item is scored from observation alone.

Item #29 - Mother usually responds verbally to child's speech. This item is very similar to that found in the Infant/Toddler version of the H.O.M.E. To receive credit for this item, the mother must respond in some verbal way to the child's speech. When the child vocalizes, the mother must say something. It can be as little as "Uh huh", "Um", or "sure", but some sound must come out of her mouth in response to what the child says. This must occur more than 50-75% of the time for credit to be given (most of the time). The key element in this item is that the mother recognizes and acknowledges the child's vocalizations, does not ignore them. Vocal responses designed to quiet or dismiss the child (such as "hush" or "not now while I'm talking") do not receive credit. If the child does not vocalize in any way during the visit, the item would be scored "no", because there was no opportunity to determine whether a response would have occurred.

Scoring Examples:

Example: Visitor notes that almost every time the child says something, the mother says something back. Score "Yes".

Example: Visitor notes that the child has not said a word that could be heard or intended for the mother during the visit. Score "No".

Example: Mother answered in some type of vocalization each time the child said something to her. Score "Yes".

Example: Mother answered the child's questions only when she was not attending to something else. That occurred in less than one half of the questions asked by the child. Score "No".

Lead-in Example:

This item is scored by observation alone.

Item #30 - Mother praises child's qualities twice during visit. This item is similar in intent to the corresponding item found on the Infant/Toddler version of the H.O.M.E. Visitors should look for spontaneous praise from the mother. If the visitor brings up a topic and leads the mother into praising the child, that praise should not count as one of the two acts of praise necessary in order to receive credit. Visitors may credit spontaneous praise offered by the mother regarding the child's looks, clothing, behavior and special skills. These skills may be in the areas of physical, social, cognitive and personal behavior. There must be at least two spontaneous praises in order to score "yes".

Scoring Examples:

Example: Mother says that (child) has the best disposition of any three year old she has seen. She later tells the visitor that she knows her colors real well. Score "Yes".

Example: Visitor asks how well (child) eats. Mother replies that she eats real well. This is the only praise she offers. Score "No".

Example: Mother tells the child that she did a good job of wiping off the table. The mother then tells the visitor that (child) also can put up the toys all by herself. Score "Yes".

Example: Mother tells the visitor with pride that (child) can throw a ball farther than anyone else in his day care. She then tells the visitor, when asked about picking up toys, that the child does a good job of that. These two praises are the only ones given. Score "No". (The second praise was in response to something you ask and, thus, set-up.) Visitors will remember from the Infant/Toddler version of H.O.M.E. that a lead-in praise does not count, but one following would.

Interviewing and Probing Example:

Visitor: How does (child) do with eating? Is she picky?

Mother: No, she is a real good eater. She will eat anything you put in front of her. **This would not be a spontaneous praise and would not count as one of the two necessary to receive credit on this item.**

Visitor: That's great. I know it must make it a lot easier for you.

Mother: It really does. And, not only does she eat well, she always cleans up her place at the table without being reminded. **This would be spontaneous praise and would count toward one of the praises needed to credit this item.** She takes her plate and cup to the kitchen and then wipes off the table. **This last statement could, also, be counted as spontaneous praise.**

Lead-in Example:

This item is scored from observation alone.

Item #31 - Mother caresses, kisses, or cuddles child during visit. Again, this item is similar in intent to one found on the Infant/Toddler version of the H.O.M.E. - it concerns physical contact designed to nurture or soothe the child. Any kiss or cuddle would receive credit. Visitors must watch closely for caresses as some of these gestures may be very subtle. Subtle caresses which would count would be: stroking a hand, stroking the hair (not fixing it), rubbing a finger or hand, rubbing a foot or knee, patting a portion of the child's body, etc. All of these more subtle caresses receive credit just as the more obvious ones do. The main thing to remember is that touches designed to convey affection receive credit, but touches mostly designed to control behavior (e.g., inhibit the child's actions) do not.

Scoring Examples:

Example: Visitor sees mother pat the child on the shoulder. Score "Yes".

Example: Visitor notices the mother rubbing the child's hand while they are waiting for the visitor to bring her things into the house and be seated. Score "yes".

Example: Visitor sees no physical contact between the mother and the child. Score "No".

Example: Visitor notices three instances of physical contact involving inhibiting the child's movements (such as stopping the child from doing something). Score "No".

Example: Visitor sees the mother pull the child's hair out of her eyes and fasten with a barrette. The visitor notes no other physical contact between the mother and the child. Score "No".

Lead-in Example:

This item is scored from observation alone.

Item #32 - Mother helps child demonstrate some achievement during visit. Any conscious act of the mother to try to get the child to do something to impress the visitor would be credited here. It is not necessary for the child to actually demonstrate some achievement in order to receive credit, just that the mother ask the child to do something to "show off" or impress the visitor. Some examples are the mother asking the child to show how she counts, to sing a song, to dance, to say her ABCs, to explain how a toy works, etc. Most mothers are proud of the children and are usually anxious to have them show "how smart" they are. If the visitor asks for the demonstration, credit should not be given. Visitors will find that this usually occurs during the discussions dealing with the items in the Academic Stimulation Subscale.

Scoring Examples:

Example: Mother asks (child) to "show Miss Leslie how you can hop". Score "Yes".

Example: Mother asks (child) to "show Miss Sandra how she can say her ABCs". Of course, the child will not say them at that time. Score "Yes".

Example: Mother asks (child) to "show Miss Frances how you can take your shoes off and then put them on again". The child actually does it at that time. Score "Yes".

Example: Mother does not ask the child to show the visitor how she can do anything. Score "No".

Lead-in Example:

This item is scored from observation alone.

Academic Stimulation

The next 5 items (33-37) are in a subscale which deals with ways the mother uses to encourage the child to develop those skills. Item #13 illustrates how these 5 items could be discussed as a group along with #13. Visitors should refer back to item #13 for details. Most of these 5 items fit easily into a discussion of

the various toys and how they are used that are found in Subscale I.

Item #33 - Child is encouraged to learn colors. Credit for this item may be given for any attempt by the mother to teach colors. It is not necessary for the sole responsibility of this item to rest with the mother. Another adult or older child (13 years or older) in the home may also perform this task and receive credit. Examples of this teaching process include: pointing out colors while dressing the child; playing with toys (see item #1); looking at books or magazines; during arts/crafts projects; nature walks; watching cars go by; flash cards and etc. The key element in this item is that the mother is actively helping the child learn about colors. This must be done at least once every 2 weeks for credit to be given.

Scoring Examples:

Example: Mother reports that the child has learned all about colors from TV and that she does not have time to do any work on that during the day. Score "No". (But probe for some of the less obvious methods that the mother might not consider formal teaching.)

Example: Mother reports that she works with the child on color recognition using flash cards. Score "Yes".

Example: Mother reports that they (the children in the family who are not in school yet) all have circle time and one day a week they go through a routine dealing with various aspects of learning colors such as naming their favorite color, finding something in the room that is that color, and then finding the crayon that is the same color, etc. Score "Yes".

Example: Mother reports she does not help (child) learn about colors, but a first grader comes in after school and does those sorts of things while they play "school". Score "No". A first grader is really not old enough to do the type of teaching expected of this item.

Lead-in Example:

Visitor: I have seen some children who know some of their colors by this age. Does (child) know any? How did she learn about them? What sort of things do you do to help her learn about them?

Visitor: I noticed earlier that (Child) was really engrossed in coloring a picture. He seemed to know just which color he wanted to use. How did he learn about colors?

Item #34 - Child is encouraged to learn patterned speech. The intent of this item is to determine whether the mother is actively engaged in helping the child to learn patterned speech. The mother does not have to take the sole responsibility for this task, credit may also be given if another adult in the home or an older child (13 years or older) performs the task. Any attempt to teach the following would receive credit: nursery rhymes, prayers, songs, TV commercials, phrases that are part of some jingle from commercials or songs, etc.

Scoring Examples:

Example: Mother reports that she has taught each of her children a prayer to say before lunch. They all take turns saying the blessing. She also has the children sing each day. Score "Yes".

Example: Mother reports that she does not do any singing with (Child), she just lets her pick up what she can from listening to the radio, records & tapes, and from programs on TV. Score "No".

Example: Mother reports that she waits until the school children arrive in the afternoon and then lets her 13 year old son teach the younger children all the songs she has long forgotten. Score "Yes".

Example: Mother reports she has an hour each week where the children who are still at home recite rhymes and then she lets them practice on a tape recorder once they have learned them pretty well. Score "Yes".

Lead-in Examples:

Visitor: Sometimes children this age can pick up all the words to the TV commercials on their own. Has (Child) done this yet? Then continue with what other patterned speech the child does and what the mother has done to help her learn them.

Visitor: I know there are a lot of nursery rhymes for little children. Does (Child) know any?

Item #35 - Child is encouraged to learn spatial relationships. Credit for this item should be given if the mother makes a deliberate and planned effort to clarify the meaning of prepositions such as: up/down, under/over, big/little, in/out, behind/in front of, underneath/on top of, etc. Credit should also be given if the mother tries to teach the child about directions or orientation in space, (left/right, ceiling/floor, in the corner out the door, across the street). Most mothers do this without really being aware of it (telling a child to pick "up" the toys and put them "in" the box). The mother does not have to take the sole responsibility for this task, credit may also be given if another adult in the home or an older child (13 years or older) performs the task.

Scoring Examples:

Example: Mother reports that she has developed an action game in which the younger children play "follow-the-leader" and do things such as put their hands in front of, stand behind, etc. Score "Yes".

Example: Even after careful probing, the mother reports that she has never done anything to help (Child) learn any of these things. She guesses (Child) just picked it up from the other kids or TV. Score "No".

Example: Mother reports that she does not do anything in this area, but her son (13 years old) has been working on in/out, top/bottom and big/little with (child). Score "Yes".

Example: Mother reports that she started having the child pick up her toys and put them in the toy box, but that she placed the emphasis on putting the toys away and not on the "up" and "in". She did say she thought that sounded like a good thing to try. Score "No".

Lead-in Examples:

Visitor: Sometimes children this age have a hard time understanding simple commands such as pick it up and put it in - those kinds of prepositions. Is (child) having any problems with those? Which ones does she know? Have you done anything to help her?

Visitor: I saw (child) picking up her toys earlier. How did she learn to put them away? I know those commands that require a preposition such as up, in, on, under etc., can be pretty hard to understand. Did you do anything special to help her learn (the ones she knows)?

Item #36 - Child is encouraged to learn numbers. Credit should be given for any attempt to teach the child numbers. Examples of such activities which could be credited include: counting toes or fingers; teaching her to hold up a certain number of fingers;

pointing out numbers in books, puzzles; using flash cards for number recognition; etc. This can also be done in the contest of playing a game (e.g. "move 3 squares", "take 2 big steps", "which one has more").The mother does not have to take the sole responsibility for this task, credit may also be given if another adult in the home or an older child (13 years or older) performs the task.

Scoring Examples:

Example: Mother reports letting her kindergarten son and his friends show (Child) how to count. Score "No".

Example: Mother reports that she lets the 12 and 13 year old neighborhood children work on rote counting with (Child) once they are in from school. Score "Yes".

Example: Mother reports that (Child) is just now counting to three by rote and can recognize the first three numbers by their figures. She can usually hold up the correct number of fingers from 1-3. The mother plans to get (Child) to count to 5 by counting with her and showing her the figures for 4 and 5 as she does. Score "Yes".

Example: Mother reports she turns on Sesame Street and (Child) learns about numbers from the show. Score "No".

Lead-in Examples:

Visitor: Kids this age seem to be real interested in being able to hold up the number of fingers for how old they are. Is (Child) into this yet? How did she learn to do that. Do you do anything to help her?

Visitor: A lot of children around this age get real interested in school and want to say the ABCs and count. Has (Child) reached that point yet? What kind of things is she doing? How high can she count? Are you doing anything to help her?

Item #37 - Child is encouraged to learn to read a few words. The intent of this item is directed toward real reading, not just trying to teach the child to recognize her name and a few letters. This item is looking at true reading skills and not pre-reading skills (actually reading a few words as opposed to recognizing a few letters).. Thus, credit for this item will most often be given to mothers' work with children at the older end of the Inventory's age limit. Mothers should take advantage of daily occurrences (such as grocery shopping, story reading, etc.) to call the child's attention to the association between the printed letters and sounds. Activities which would receive credit include: reading alphabet books; giving the child paper and pencil and letting her copy letters; responding to the child's "what's that word", pointing out words on packages, signs, etc. Credit for this item calls for direct mother activity. Just letting the child play a computer game, work with flash cards or read on her own does not meet the intent of the item. These things are good activities, but must be incorporated with direct teaching activities on the mother's part to help the child understand the associations between what she sees and hears and says. The mother does not have to take the sole responsibility for this task, credit may also be given if another adult in the home or an older child (13 years or older) performs the task. This activity should be worked on at least once a week for credit to be given.

Scoring Examples:

Example: Mother reports that she has started teaching (Child) A, B, C, and D - just by looking at the letters and saying them. Score "No".

Example: Mother reports that she is teaching (Child) to say her ABCs, but has not started showing her the letters yet, let alone started any reading activities. Score "No".

Example: Mother reports she noticed (Child) reading a few words about four months ago. She thought, at first, that he had just memorized the book, but when she got a new book and sat down to read to him, he started saying a few words. At that point she started showing him new words and explaining what they stood for and how to say them. She even made some "flash card" games to match some of the new words they were working on to the objects. Score "Yes".

Example: Mother reports that (Child) has shown no interest in reading and besides she thinks 3 year olds should play - they can learn to read when they go to school - that's one of the reasons they go to school - Score "No".

Lead-in Examples:

Visitor: I noticed the children playing school over there a while ago. Does (Child) like to do that? Does she try to read any words yet?

Visitor: I see (Child) reading a book. She is talking, but I am curious - is she really reading, just pretending or has she memorized the book?

Modeling

Item #38 - Some delay of food gratification is expected. The intent of this item is to determine whether the mother requires the child to control his/her desire to eat, to wait until the time designated for eating comes. The hope is that the child will learn to delay gratification, a sign of maturity. In scoring this item, the visitor should look at such things as: does the child snack at any time she wants; does the mother refuse to tolerate whining during the last 30 minutes of meal preparation. The visitor may wish to discuss this when talking about meal times. Credit would be given if: child is not allowed to snack whenever she chooses; child is not permitted a snack within 30 minutes of a meal; child is not permitted to nibble all day; etc. The item supposes that the mother has reasonable snack and mealtime schedules and is providing enough food to sustain the child from one eating period to another. The visitor should ask the mother what rules/standards she uses and whether the child is really hungry, hungrier than usual (due to unusual physical activity) or if s/he is just bored. A mother who moves a snack or meal time up would not be scored "no" provided she has done so for a good reason, such as the child having an unusual amount of strenuous physical activity the past few days, etc. Visitors should also probe to determine if the mother explains to the child **why** s/he must wait. Credit may be given for any type of (reasonable) delay imposed but credit should not be given if the reason for the delay is to punish the child or merely to assert the mother's dominance.

Scoring Examples:

Example: Mother reports that lunch is served whenever she has taken care of the baby. It usually is within an hour or two of 11:30. It all just depends on how long it takes to feed and change the baby's diapers. Score "No". An hour either before or after the designated time is too long for a child to delay a meal. Fifteen to 20 minutes (no more than 30 minutes) either way would receive credit.

Example: Mother reports that she has a cabinet with crackers and cookies that is within the child's reach. The child is allowed to go get some whenever she wants. Score "No".

Example: Mother reports that she may move snack time by 5-15 minutes either way, depending on how involved they all are in an activity. She does say that if (Child) and the other children are begging for lunch 20-30 minutes before the time to eat, she explains to them that they must wait just a little longer until it is ready. Score "Yes".

Example: Mother reports that snacks are around the same time every morning and afternoon. She reports that she has pretty well figured out when the child needs to eat something to hold her over until meal time. She also reports that when (Child) asks for something to eat shortly before a meal, she usually asks her to wait (telling her it won't be much longer before it is ready), but she has on occasion given her one cracker to nibble until lunch is ready, especially if she has been unusually active that day. Score "Yes".

Lead-in Examples:

Visitor: We were talking about the eating earlier and I just wondered if (Child) ever wants to eat before lunch is ready? How do you handle that - especially with more than one child?

Visitor: (Child) is really doing a lot of running around. I bet she gets hungry today. Sometimes 3 year olds can really eat and at just about any time of the day. Does (Child) ever want to eat before lunch is ready or between snack time and lunch?

Item #39 - TV is used judiciously. The main intent of this item is to determine if any attempt at regulating use of the TV is made. If the home has no TV, an automatic score of "no" is given. If the TV is turned on in the morning and not turned off until bedtime (with no regard to the program) an automatic score of "no" is given. If the TV is on most of the child's waking hours, an automatic score of "no" is given. Almost any attempt at regulating or scheduling will receive credit; but the regulation should be meaningful to the child's personal situation (e.g., if child's bedtime is 9:00 PM, it doesn't mean anything that the TV is shut off at 10:00 PM). Regulating which would receive credit would include: allowing children to watch only certain types of programs; allowing children to watch only a certain number of programs; allowing children to watch only for a certain number of hours or minutes a day; TV turned off at meal times, nap times, when the children are involved in other activities. If a child is allowed to watch TV at any time s/he wishes except when another family member is watching a show, credit should not be given.

Scoring Examples:

Example: Mother reports that the child is allowed to watch only Sesame Street and Barney during the day. Score "Yes".

Example: Mother reports that there is no TV in the home. Score "No".

Example: Mother reports that there is no TV in the room used for play, but that she does take (Child) upstairs each afternoon so she can watch Barney. Score "Yes".

Example: Mother reports that she limits the amount of time (Child) can watch TV to two hours in the morning and two hours in the afternoon. Score "Yes".

Example: Mother reports leaving the TV on all day because it is the best baby-sitter around. Score "No".

Lead-in Examples:

Visitor: I know that TV can be a lot of company. Do you usually leave it on all day or just turn it on for special programs?

Visitor: Often watching TV can really keep the kids occupied. Does (Child) like to watch TV? How often does she watch?

Item #40 - Mother introduces visitor to child. In introducing the visitor to the child, the mother is indicating that the visitor has come to visit both of them. In order to receive credit, the mother must remind the child of the visitor's name, even if the child already knows the visitor. The key to this item is that the mother must tell the child the visitor's name.

Scoring Examples:

Example: (Child), this is Miss Frances. She has come to watch you play today. Score "Yes".

Example: (Child), you remember Miss Brenda. She was here a few months ago to see you. Score "Yes".

Example: (Mother to visitor) That's (Child) over there in the blue shirt. Score "No".

Example: (Child) just go on and play. This lady has come to talk to me Score "No".

Lead-in Examples:

This item is scored from observation alone.

Item #41 - Child can express negative feelings without harsh reprisal. The intent of this item is to determine if the mother uses "harsh" punishment when the child expresses negative feelings. The mother may set limits and use punishment which is not considered harsh yet still receive credit. The visitor must first determine if the child does (or has ever done) these things. Then the visitor must determine what the mother does when it happens. Finally, a determination must be made as to whether or not the reprisal is "harsh". Some of the negative feelings expressed by the child would include: I don't like you; I hate you; I don't want to; No, I won't; etc. Harsh reprisals from the mother would include such things as: spanking the child (or using any type of physical punishment which hurts the child); yelling at the child; putting the child in time-out for an unreasonable length of time; withholding privileges; overbearing lecture; yelling and threatening the child to keep him in time-out; threatening the child in a way that is cruel or frightening; etc. Negative expressions (a big scene as in a temper tantrum or a little scene as in an "I don't like you") which typically result in a "big scene" would be scored "no".

Scoring Examples:

Example: Mother reports "just picking him up and "beating the tar" out of him". Score "No".

Example: Mother reports sending the child to the time-out chair for 5 minutes. Score "Yes".

Example: Mother reports sending her to her room until she gets over it. It usually takes 1-1 1/2 hours. Score "No".

Example: Mother reports that what she does depends on what the child does. For things like "I don't like you" she just talks to the child. For temper tantrums, she sends the child to the time-out chair for 5-15 minutes. Score "Yes".

Lead-in Examples:

Visitor: I have heard a lot of children who, by this age, have started expressing negative feelings such as "I hate you" or "No, I won't do that". Does (Child) do anything like that? What kinds of things has she expressed? How do you deal with each of those expressions?

Visitor: Sometimes kids have bad days just like the rest of us. They have what I call "the don't wants". They don't want to do this or they don't like that.

Does (Child) ever say negative things like that or have temper tantrums?

Item #42 - Child can hit parent without harsh reprisal. Once again, in this item the key is "harsh reprisal". A harsh reprisal would be physical punishment that hurts the child or any cruel or extreme disciplinary procedure. If the child has never hit the mother, score "yes". It is important to note that parents are allowed to set limits and can punish the child for hitting them and still receive credit for this item **as long as the reprisal is not harsh.** Visitors should first determine whether or not the child has hit the parent. Then probe to determine what the parent does when it happens.

Scoring Examples:

Example: Mother reports that (Child) has never hit her. She has hit some of the other children, but never her. Score "Yes".

Example: Mother reports that she will not allow (Child) or any of her other children to hit her. She hits them back to show them how it feels. Score "No".

Example: Mother reports that she tells the child how sorry she is that he hit her - that she really likes him and would not hit him. Then she asks why he hit her - if it is because she would not let him do something, she explains why. She reports that only once did she have to put him in time-out for about 5 minutes. Score "Yes".

Example: Mother reports she will not have a child hitting her. She just sends the child to her room and makes her stay there the rest of the day. Score "No".

Lead-in Examples:

Visitor: There is something I have been interested in. I have seen children around this age hit their mother. Has (Child) ever hit you? How do you deal with something like that?

Visitor: I know that around this age children can really express their negative feelings and sometimes they even express them by hitting. Has (child) ever done anything like that to you? I am interested in what you do and how well it works.

Item #43 - At least 1 musical instrument is available to the child. For this item any type of musical instrument (real or toy) will receive credit as long as the child can actually use it to make music (i.e. a cheap plastic miniature toy horn would not count). They would include: piano, drum, xylophone, guitar, horn, radio, etc. The instrument does not have to belong to the child personally, it may be shared. However, the child must be permitted to use it whenever s/he chooses in order to credit this item.

Scoring Examples:

Example: Mother has drums, horns, cymbals and all are available to be used by (Child) as well as her other children when they want, not just during a special time. Score "Yes".

Example: Mother has horns, drums and bells that are kept up and only used for music hour. She does have a toy piano which is kept out and can be used by (Child) at any time during the day. Score "Yes".

Example: Mother reports having toy instruments, but none are seen out. Upon probing, the visitor discovers that the toys are kept on the top shelf of a closet and brought down only when the mother "feels like it". Score "No".

Example: Mother reports having no toy or real instruments. Score "No".

Lead-in Examples:

Visitor: Children this age seem to really enjoy music. Do you have any kind of musical instruments, either real or toy? How often does (Child) use them?

Visitor: I see a toy piano over there, does (Child) ever play it?

Variety

Item #44 - Child is taken on an outing by a family member at least every other week. The intent of this item is that the child is exposed to a variety of experiences. The child needs to do more than play outdoors in the yard or take a weekly walk around the block. Visitors should be looking for educational types of trips. Excursions which would receive credit include: a trip to the mall, a trip to the barber and/or beauty shop, a picnic in the park, a trip to the zoo, a trip to a farm, a trip to a movie, a trip to the ice-cream shop, etc. Simply going to another mother's home to play with other children is not sufficient to receive credit if that is the only type of excursion taken. The mother does not have to take the sole responsibility for this task, credit may also be given if another adult in the home or an older child (13 years or older) performs the task.

Scoring Examples:

Example: Mother reports going somewhere every week. They usually go to the zoo once a month, the library, the mall, the pet store, etc. Score "Yes".

Example: Mother reports they only walk down the street to visit a lady who keeps children and has a big back yard full of swings and other toys. Score "No".

Example: Mother reports going somewhere every other week such as the mall, the library, the zoo, etc. Score "Yes".

Example: Mother reports that the neighborhood is so unsafe that she does not take her children out for any type of outings. Score "No".

Lead-in Examples:

Visitor: Children this age often like to go places. Do you ever take (Child) any place besides out in the yard? Where are some of the places you go? How often do you get to do that?

Visitor: I see (Child) carrying her purse around like she is going somewhere. Does she ever want you to take her places? Do you ever have the time to do that? Where are some of the places you go? How often do you get a chance to do that?

Item #45 - Child has been on a trip of more than 50 miles during the last year. For this item the trip may include most any type of excursion such as a vacation type, a trip to visit relatives, a religious retreat, a shopping trip, etc. The trip must be at least 50 miles each way, not round trip. The intent of the item is that the child has an opportunity to experience environments and activities outside his/her normal realm. The trip must have occurred within 12 months of the visit in order to receive credit.

Scoring Examples:

Example: Mother reports the family went to Disney World last month, a trip of approximately 1300 miles each way. Score "Yes".

Example: Mother reports that she and the older children went to New Orleans (550 miles round trip) last week, but left (Child) at home with the father. Score "No".

Example: Mother reports that they went to visit her mother who lives 135 miles away. Score "Yes".

Example: Mother reports that she took (Child) to see a special physician in Denver (23 miles away). Score "No".

Example: Mother reports that they have not been able to afford to take any trips anywhere except to the grocery store. Score "No".

Lead-in Examples:

Visitor: I know how busy you must be with four children, all under school age, but I was wondering if you ever got a chance to take a trip to visit relatives, sightsee, shop, or just to get away for a while?

Visitor: You talked earlier about the places you and your husband take (Child) here in town. Do you ever go on any trips out of town?

Item #46 - Child has been taken to a museum during the past year. In this item visitors should look for the types of places which would offer the child an opportunity to see and experience things s/he would not in the regular home environment. Visitors should look for experiences which would foster growth and learning. The trip should have occurred within 12 months of the home visit. Almost any type of museum would receive credit - a local art center, a clock museum, natural history museum, an art exhibit held in a local bank or shopping mall. Things which would not receive credit would include the zoo, a craft show and sale, stores, story time at the library, etc.

Scoring Examples:

Example: Mother reports that she has taken (Child) to the art center within the last month. Score "Yes".

Example: Mother reports that she took all the children and even two cousins to an Indian Pow Wow. Score "Yes".

Example: Mother reports that she took (Child) to the zoo last week. Score "No".

Example: Mother reports she has not taken the children to any type of museum. Score "No".

Example: Mother reports that she took (Child) to an art show in a trailer. It is the traveling art exhibit sponsored by the state university art department and it comes every 3 months. Score "Yes".

Lead-in Examples:

Visitor: You have been talking about all of the places you and your family go and take (Child), have you ever taken her to a museum of any type?

Visitor: Earlier you talked about enjoying taking (Child) to the zoo and how much you both liked to talk about the animals that I was wondering if you have ever gone to anything like an art show or any type of historical museum, etc.?

Item #47 - Parent encourages child to put away toys without help. In order to receive credit for this item, the child does not actually have to comply each time s/he is asked. Rather credit is given for the mother actually trying to get the child to do so without her help, instead of the mother doing it herself because it is easier. Credit should be given as long as the mother tries. The mother does not have to take the sole responsibility for this task, credit may also be given if another adult in the home or an older child (13 years or older) performs the task. The visitor may probe for when toys are put away, such as after a play session, before lunch, before going outside, before nap time, etc.

Scoring Examples:

Example: Mother reports it is just easier to do it herself. Score "No".

Example: Mother reports she asks (Child) to put them away and he usually does, but they don't always get put on the right shelf. Score "Yes".

Example: Mother reports that she has all of her older children put the toys away, even though (Child) sometimes tries to help them. She has never asked (Child) to put the toys away as that is the older kids job. Score "No".

Example: Mother reports that (Child) has been picking up the toys he uses as well as those used by the older children. He even knows where they belong and will bring her those that go on shelves that are too high for him to reach. Score "Yes".

Lead-in Examples:

Visitor: It seems like kids this age are always wanting to help you around the house. Does (Child) like to help you? What kind of things does she do? Do you ever try to get her to pick up her toys?

Visitor: I noticed that you asked your two older children to pick up the toys before lunch. Do you do that every day? Does (Child) ever get asked to help?

Item #48 - Mother uses complex sentence structure and vocabulary. Credit should be given if the mother makes an attempt to carry on a regular conversation instead of just answering all questions with "yes", "no", or "I don't know", or other brief responses. The mother must give some elaboration beyond simple one word or one phrase answers. The mother must use some sentences that contain 2 or more clauses and some words that are unusual or poly-syllabic. Constant use of short sentences results in a "no" score. The visitor should not base the score for this item on the first few minutes of the visit, especially if it is the first time she is visiting this mother, since the mother may be nervous.

Scoring Examples:

Example: Mother's reply to "Does (Child) ever put her toys away?" is "yes." Score "No".

Example: Mother's reply to "Does (Child) ever put her toys away?" is, "Yes, I always ask him to pick them up by himself to show me what a big boy he is and how much help he is to me." Score "Yes".

Example: Mother's reply to "Does (Child) ever put her toys away?" is, "Yes, I try to." Score "No".

Example: Mother's reply to "Does (Child) ever put his toys away?" is, "I ask him, but he never has." Score "Yes".

Lead-in Examples:

This item is scored by observation alone.

Item #49 - Child's art work is displayed in some visible place in the home. The art work can be anything the child has drawn or constructed. If the work cannot be observed in the room(s) where the visit is conducted, the visitor should probe to determine if the art is displayed somewhere. In order to receive credit, the mother must have some work by the child displayed in some area visible to the child and others in the home. The only time this item would receive credit when no art work was displayed is when the mother is in the process of changing a display when the visitor arrives.

Scoring Examples:

Example: Mother says she put up work each week and leaves it up for about 2 days. Score "No".

Example: Visitor notices the child's drawings on the refrigerator door while there for the visit. Score "yes".

Example: Mother has placed all the child's work in a scrapbook. Score "No".

Example: Mother has a rope strung in one corner of the playroom, like a clothes line. She has it divided into sections so that each of her children can hang their art work up and change it as they wish. Score "Yes".

Lead-in Examples: This item is usually scored from observation, but there are circumstances where it may be necessary to ask.

Visitor: You mentioned earlier that (Child) likes to color. What do you do with her pictures when she has finished?

Visitor: I see some art masterpieces being stuffed into a paper bag. Do you let (Child) have all of her art work to do with what s/he wants or do you save any?

Item #50 - Child eats at least one meal per day with mother (or mother figure) and father (or father figure). This item is similar to the item dealing with mealtime in the Infant/Toddler version of the H.O.M.E. used during the 6 and 15 month assessment periods. One parent families receive an automatic "no" score, as do same sex partners. The meal can be any during the day, but it must be a meal and not a snack. Five meals per week must be eaten together in order to credit this item, unless there have been unusual circumstances such as an illness in the family, etc. If one parent works shift work and the meal times do not coincide, a score of "no" would be given. If work hours vary for one or both parents and these schedules change from week to week or month to month, credit would not be given. The child must sit with the mother and father (or mother/father figures) at the table or in a high chair/booster seat pulled up to the table. In some situations visitors will find that the mother reports the family eats in the den/living room in front of the TV. In a situation such as this the visitor needs to probe to determine whether the TV is the focal point of the family being in that room or if the TV is on and ignored while the family eats together. Visitors should look for the socialization aspects of a meal. Credit may be given if the child is fed earlier but is sitting with the parents while they eat.

Scoring Examples:

Example: Mother reports that (Child) eats with the other children but sits with the parents when they eat later. Score "Yes".

Example: Mother reports that (Child) eats with the other children and is in bed by the time the parents eat. Score "No".

Example: Mother reports that she is working at night and her husband is working in the afternoon and they are never home for a meal as a family. Score "No".

Example: Mother reports that she and her roommate, Mary, eat dinner with (Child) each night. Score "No".

Example: Mother reports that she and her father, who lives with her since her divorce, eat breakfast with (Child) every morning. Score "Yes".

Lead-in Examples:

Visitor: How do you handle meal time at your home?

Visitor: You have been telling me about all the things you do. I can't imagine where you find the time to do everything. Do you find time to sit down and eat a meal? Do you manage to find time to eat with the family?

Item #51 - Parent lets child choose certain favorite food products or brands at grocery store. The intent of this item is that the child is given a choice in the foods s/he is allowed to eat. The mother may set limits (such as letting the child choose between certain cereals, no candy, etc.). The child must be allowed to go to the grocery store with the mother and/or father at least once every two weeks in order to credit this item with a score of "yes". If there are several children in the family, there must be some type of rotating system whereby the study child is allowed to make selections on a reasonable basis (such as no less than one choice every two weeks). If the child is never allowed to go to the store, the item automatically receives a score of "no".

Scoring Examples:

Example: Mother reports that she lets (Child) pick one fruit and one cereal (from her list of 5 acceptable cereals) each week. Score "Yes".

Example: Mother reports that when you have 6 kids you just buy the cheapest brands or the brands you have coupons for and don't ask anyone. Score "No".

Example: Mother reports that it is hard with 6 kids to give each a choice. She reports that she makes her grocery list and checks her coupons. If there are several coupons she will give each child a turn at choosing. She reports that she always has enough to let each child choose (between coupon products) every other week. Score "Yes".

Example: Mother reports that just having the one child really does not make it easier. She says that if she lets him go to the store, he does nothing but scream for all the junk foods and toys he sees. She reports that she only takes him when she can't find anyone to leave him with. Score "No".

Lead-in Examples:

Visitor: Often at this age children will have very definite ideas of what they should or want to eat, usually from watching TV commercials. Has (Child) started wanting everything he sees on TV? Does he go to the store with you? How do you handle his asking for things he sees on the shelf that he has seen on TV?

Visitor: You mentioned that (Child) was a very picky eater. Has he started telling you which brands or types of foods he wants? How do you deal with his demands in the grocery store? How often do you let him go to the store with you?

Acceptance

Item #52 - Mother does not scold or derogate or yell at child more than once during the visit. The intent of this item is to determine whether the mother speaks to the child in a cruel, demeaning, or abusive manner. All remarks must be directed at the child, they may not be told to the visitor. (Mother tells child "you are a bad boy" would be counted, but the mother telling the visitor "he is a bad boy" would not.) There must be two such instances in order to score "no".

Scoring Examples:

Example: Mother tells child, "you are just awful". Count as one of the two needed to score "no".

Example: Mother tells the visitor that, "(Child) is so mean". This would not count as one of the two needed to score "no".

Example: Mother yells, at the top of her lungs, "(Child) get out of my drawer." Count as one of the two needed to score "no".

Example: Mother tells the visitor that she is, "going to skin him alive if he doesn't stop that." This would not count as one of the two needed to score "no".

Lead-in Examples:

This item is scored by observation alone.

Item #53 - Mother does not use physical restraint during visit. Any act which restrains the child physically would result in a score of "no". Acts which would be considered physical restraint include: forcing a child to sit in a chair; jerking him back from handling objects; grabbing the child; shaking the child; holding the child down. etc. Do not confuse this with regular time-out procedures (i.e.. Mother tells child to go sit in time-out chair - this would not be use of physical restraint. But a mother who pushes the child bodily into the time-out chair would be scored as using physical restraint.)

Scoring Examples:

Example: Mother forces child stand on a square until he says I'm sorry. Score "No".

Example: Mother jerks child's hand away from the cookie jar. Score "No".

Example: Mother jerks child, bodily, away from the visitor. Score "No".

Example: Mother shakes child when he stops listening to her. Score "No".

Lead-in Examples:

This item is scored on observation alone.

Item #54 - Mother neither slaps nor spanks child during visit. This item is fairly self-explanatory. Slaps and spanks must be done in anger to score "no". An affectionate pat on the bottom as the child goes out to play would not be scored "no". The visitor must watch those situations where the roughhousing between a mother and a child includes slapping or spanking as part of the tussle. Watch the child's expression. This expression is usually a good indicator of when hitting stops being play and becomes punishment or abuse.

Scoring Examples:

Example: Mother slaps the child as he reaches for a cookie. Score "No".

Example: Mother spanks the child for hitting another child. Score "No"

Example: Mother gives the child an affectionate spank on the bottom - the child grins the whole time. Score "Yes".

Example: Mother playfully spanks the child because it is his birthday. The child is laughing so hard his face is red. Score "Yes".

Lead-in Examples

This item is scored from observation alone.

Item #55 - No more than one instance of physical punishment has occurred during the past week. This item is similar to the item dealing with physical punishment in the Infant/Toddler version of the H.O.M.E. used for earlier assessment periods. The key to this item is that the instance of punishment must have occurred during the past week. Remember, it is not asking for how many times the child is generally punished in a week. Physical punishment can include; spanking, slapping, hitting, pinching, shaking, hand slapping, etc.

Scoring Examples:

Example: Mother reports that she has not had to spank (Child) in the past week, although she did have to slap his hands about four times. Score "No".

Example: Mother reports that the only thing she has had to do in the last week was spank him once. Score "Yes".

Example: Mother reports she has to spank (Child) at least once a day. Score "No".

Example: Mother reports she uses no physical punishment, only time-out. Score "Yes".

Lead-in Examples:

Visitor: With 5 children in your family you must be forced to have some rules for the children to follow. What are some you have for (Child)? What do you do when she does not follow them? Do you ever have to spank her or use any physical punishment to get her to mind?

Visitor: We are interested in finding what types of discipline mothers use and what works best for them. What do you do when (Child) does not mind?

V. HANDLING UNUSUAL CIRCUMSTANCE

A. What Should The Visitor Do If The Mother Begins To Get Restless During The Interview?

The key to this problem is prevention. This generally should not happen if you have given the parent an indication of how long the procedure will take, this generally should not happen. Also, if the Visitor uses the proper style in conducting the visit, restlessness should not be a problem. Restlessness occurs more often when: (a) the interview seems too much like just a series of questions to which the parent must supply answers; (b) when the Visitor dominates the interchange. Don't be afraid to let the conversation wander a bit even into areas not covered by items on the HOME. The situation will seem more "real" and answers are likely to be more candid and complete. Don't be afraid to let the parents talk about things they are interested in. It is easy to eventually get back to the topic covered in the items. Don't be afraid to disrupt the interview for a while: to engage the child, to move physically from where you are sitting, etc. The Visitor is a manager, not a technician. She must sense when to change gears, change directions, change style or tempo. The goal is set. The visitor must use insight and creativity to reach it, not force, or rigid adherence to a script. However, if she detects this reaction in spite of very careful preparation, it is good to offer to discontinue the interview and to arrange for another appointment. The mother will most likely suggest that it will be all right to go ahead and complete it while the Visitor is there.

B. What Should The Visitor Do If She Senses That The Mother Is Trying To Report What She Thinks She Should Be Doing With Her Child Rather Than What She Actually Does?

A good indication that you have encouraged this kind of parent will be frequent questions such as, "*What do you think about that--am I doing the right thing?*" An attitude of honesty and ingenuousness on the part of the Visitor will be important here. She must communicate the idea that we have some ideas about conditions that favor the development of children but do not have any hard and fast knowledge. The Visitor should try to convince the parent that the knowledge she supplies will be helpful to us in our attempts to understand the relationship between certain conditions and the development of children. The Visitor's ability to convey this will probably be affected by her own attitude or understanding of the intent of the interview. The intent of the procedure is to describe rather than evaluate and to get information rather than express opinions or make suggestions. If this is remembered, the Visitor will not fall too readily into this trap. The respondent does not pass or fail the HOME as a whole. In generating the items an assumption was made that certain experiences and objects, if present or absent in the daily life of a child, can make a difference in that child's social and cognitive development. Any mother who is concerned about her response to one particular item should be reassured by the fact that we do not have positive proof that any one of these conditions is essential for nourishing child development. We expect that in the analyst we will find some items that do not significantly correlate with the child's development, in which case they will be replaced. Relatedly, the home environment of a child may include some compensating factors not currently indexed on HOME.

VI. TRAINING AND CERTIFICATION

The purpose of this section is to specify procedures for training and certifying a home visitor on the HOME Inventory. Standards for certification are established in two areas: 1) scoring of individual items, and 2) general approach to administration. It is essential that both be evaluated in determining whether a Visitor is adequately prepared to use the HOME in the NICHD Study of Early Child Care since there is need to ensure both validity of individual measurements and comparability across measurements. Since what is being evaluated in these two areas is different, the approaches to verifying that standards are met are different. For area #1, a precise target is set for match to standard (we are requiring a 90%) match to standard.) For area #2, which includes style issues as well as skill issues, a more general appraisal will be used that involves rating the visitor on behaviors used when administering the HOME.

VII. H.O.M.E. CERTIFICATION PROCEDURES FOR THE 36 MONTH HOME VISIT

The certification process for the H.O.M.E. will begin with home visitors studying the manual, newsletters, H.O.M.E. updates and training tapes.

A. Initial Certification

There are three criteria which must be met for initial certification to be achieved. They are:

1. Self Administration Video Tape - each home visitor will administer the H.O.M.E. in a home setting. This entire administration of the 36 month H.O.M.E. will be video taped. (This may be done on a pilot or volunteer and need not include the other home visit procedures.) This video tape will then be scored by the home visitor. Scoring should be based exclusively on what is obtained from the video tape, not on observations made during the visit that are not recorded on the tape. Each item on the score sheet should be scored "yes" or " no". A reliability score of 90% or greater with a master coder from the Arkansas site must be achieved in order to pass this portion of initial certification.

2. Reliability Test - a certification reliability video tape will be provided by the Arkansas site. Criterion scoring has been developed for each item based on information contained in the video tape. All items will be marked "yes" or "no". In order to be certified, the home visitor must be in agreement with criterion scoring on 50 of 55 items.

3. Interviewer Monitoring Form - this form is a checklist of visitor behaviors to be reviewed in making an overall appraisal of the manner in which s/he administered the H.O.M.E. This form is completed by the master scorer when reviewing the home visitor's self-administration video tape. This checklist contains 14 items. It covers such areas as sufficient probing, failing to probe, leading and embarrassing questions, pacing, visitor attitude, listening techniques, body language, etc. Each behavior on the checklist will be rated on a 5-point scale and an overall score derived To achieve initial certification, the home visitor must score 55 out of 70 points on the rating scale and must receive no rating of "1" on any of the items. In addition, observers must have no less than 3 H.O.M.E. items that were neither seen on the tape nor discussed by the visitor and no less than 3 items which were asked/discussed and scored based on the incorrect intent of the item.

One through three above must be met as specified in order to receive initial certification. Should one or more of the three areas not be passed, the visitor must take a make-up test.

B. Make-up Tests

The Make-up test(s) taken will be determined by the test(s) failed. The procedures are:

1. Self-Administration Video Tape Failed - If the self-administration video tape was less than 90% reliable with the master scorer, but the reliability test tape and the monitoring form were passed, the visitor will submit a second self-administration video tape and score sheet. If this procedure is not passed, data should be collected.
2. Certification Reliability Video Test Failed - If the home visitor does not match 50 out of 55 items with the criterion score, but the self administration video tape and monitoring form are passed, s/he will take a second reliability test. If the second reliability test is failed, the visitor will repeat the entire initial certification process (a new self-administration video tape with score sheet and a third reliability test). If this procedure is not passed, data should not be collected on the H.O.M.E.
3. Monitoring Form Failed - If the monitoring form on any one of the four elements (total score of less than 55, a

rating of "1" on any item, 4 or more items not discussed or seen on the tape and/or 4 or more items probed/discussed with the wrong intent) is failed, the home visitor must submit a second self-administration video tape with score sheet. If the second tape is not passed, data should not be collected.

C. Drift/Recertification Procedures

Approximately mid-way through the 36 month assessment period, home visitors will take a drift/recertification test. Each site should designate one home visitor to be the site "expert" for the H.O.M.E. All other home visitors at the site will be considered "team members". The procedures for recertification are as follow:

1. Site "expert" - the person chosen to be the site expert will make a video tape of him/herself administering the H.O.M.E. in a home setting. The site expert will then score the video tape based exclusively on what is seen and heard on the tape. In order to maintain certification, the site expert must have a reliability score of 90% or greater with the master coder at the Arkansas site. The site expert must also meet all requirements for the Monitoring Form as discussed in A. 3 above.
2. Site "team member(s)" - without having seen the site expert's score sheet or discussed the tape's contents, each team member will view and score the video tape made

by the site expert. In order to achieve recertification, the team member must have a reliability score of 90% or greater with the master coder at the Arkansas site.

3. Scoring for both the site expert and site team members will follow procedures outlined for initial certification. The video tape, the expert's score sheet and those of the team members will be sent to the Arkansas site by the designated date.
4. Certification Reliability Test Tape - the Arkansas site may choose to add a reliability test tape to the drift/-recertification procedures. In the event this step is taken, each home visitor will take the test in the same manner as for initial certification. Each visitor must score 50 out of 55 items with the criterion score sheet in order to pass. If this test is added to the drift/recertification testing regime, sites will be notified and instructions will sent with the video test tapes.
5. Drift/Recertification Make-up Procedures - the site expert and the team member(s) must have a reliability score of 90% or greater with the Arkansas master coder in order to pass. If the site expert fails, s/he must submit a new self-administration tape and score sheet. If a team member fails, s/he will then submit a self-administration tape and score sheet. If a team

member is reliable with the master coder at Arkansas but is not reliable at the 90% level with the site expert, s/he will accompany the site expert on 5 visits, scoring the H.O.M.E. which will be administered and scored by the site expert. The expert and the member should discuss and review items (from the site tape) which were not agreed upon before beginning these visits and after each visit. Copies of these score sheets (from both the expert and the team member) should be sent to the Arkansas site within 3 days of the visit. If 90% reliability is not reached on those scores, the team member will submit a self-administration tape. Any home visitor who fails a drift test should not collect data until make-up procedures have been passed.

D. Provisional Certification

On occasion, the Arkansas site may choose to award provisional certification to a home visitor. Provisional certification will not be awarded often or on a wholesale basis, but rather rarely and only on an individual basis. Awarding provisional certification will be based on the type and severity of errors. When provisional certification is awarded, procedures for remedial study and certification will be determined by the Arkansas site on an individual basis.

E. New Personnel

When new personnel join a site's home team during the 36 month assessment period, initial certification procedures will follow those outlined above. Initial certification must be achieved before data can be collected.

F. Data Collection Improvement

Should the Arkansas site detect patterns of error on an individual or site basis, those patterns will be reported to the site coordinator and project directors, along with suggestions for making the necessary changes.

ADDENDUM A: Key and Explanations Items #1-11

Item #1. Score "Yes". The mother has two toys (shape sorter puzzle and nesting dolls) and she uses them to teach colors **and** sizes **and** shapes. If she had only the shape sorter puzzle and used that to teach colors and shapes, but had nothing to teach sizes, the score would have been "no".

Item #2 - If the puzzles are available to the child, the score would be "yes". However, this conversation did not continue long enough for the visitor to ask (if she did not see) where the puzzles were kept. If the visitor did not see the puzzles and the only information she has is that printed here, the score would be "no". Although there were 3 or more puzzles, she does not know if they are available to the child.

Item #3 - From the information listed in this conversation, observers would have to score "no". Although the child is allowed to operate the tape recorder and has a tape of songs, the visitor did not probe to determine if there were more children's tapes available. The item calls for 5 or more children's records or tapes. Had the conversation continued and the observer probed to determine the number of tapes, it is possible that the score could be different.

Item #4. Score "Yes". The crayons & paper and play dough are out and within the child's reach (available) at all times.

Item #5. Score "Yes". Crayons & paper and legos are available at all times and the scissors are brought out when he wants them. The restriction of the mother not bringing the scissors out when she is feeding the baby is acceptable and well within reason for scoring purposes of this item.

Item #6. Score "Yes". The mother has more than two toys or games available to the child and she reports she helps the child use them to learn numbers.

Item #7. Score "Yes". Two shelves of children's books are available to the child.

Item #8. Score "Yes". This is a clear "yes" on both counts. The mother has approximately 10 books in the caregiving area at all times and many more in the den that the children see daily.

Item #9 - Example #1 would be scored "no". However, I feel there should be more probing to determine if the mother ever uses their nap time for reading the front page of the paper.

Example #2 would be scored "yes". The child is usually not asleep when the mother begins reading the paper.

She also reports the child is in a position to see her reading if he so desires.

Item #10 - Example #2 is the only conversation with enough discussion to score. Score "YES". The mother buys two magazines at the grocery store on a regular basis. They are the same two magazines.

Item #11 -Score "YES". The mother has been helping the child learn shapes for the last three months

ADDENDUM TO CHAPTER 28.4
INFORMATION REGARDING THE 36 MONTH STANDARDIZED INTERVIEW AND QUESTIONNAIRES

I. Questions and Answers Regarding the 36 Month Standardized Interview

A. Section I of 36 Month Standardized Interview

(1) Household Composition - How should interviewers code a person whose household status has changed since the last contact point from a full-time resident to a part-time resident or vice versa?

Since there is not a code during Phase I to indicate a change from full-time to part-time or vice versa, such situations may be coded as "moving out" on one grid and "moving in" on the other grid.

(2) Household Composition - How should interviewers code fathers/partners who travel during the week for work and thus are home for only a couple of days a week?

According to the manual, "All adults who live in the mother's household who DO NOT have permanent residences elsewhere are considered to be full-time residents." Therefore, these fathers/partners should be coded as full-time residents of the mother's household. (Rented or hotel rooms used while working are not permanent residences.)

(3) Questions 11-14 refer to the mother's and child's contact with the father, how should these questions be coded in cases where the father is deceased?

When this situation is encountered do NOT ask these questions, but do code question 11 as "no contact" and questions 12-14 as "No". Make sure, however, to clearly indicate that the father is deceased in the subject's file so that these questions are not mistakenly asked in a future interview.

(4) Family Health - Many children are going back to their doctors for lead tests (it is by law part of the child's yearly check-up). Would these following visits be considered as follow-up visits or other?

Count routine (i.e.required by law) lead check-ups as routine visits (even if these are regular follow-ups). However, if the child is taken for a lead test because of suspected poisoning, this should go under "Injury" (or "illness from poisoning"). Subsequent testing after a non-routine lead test can be counted as a "follow-up" check.

(5) Family Health - Question #23: The manual is a bit confusing as to what you ask the mothers if she was told that her child had special needs in the past (referring to the 15 and 24 month interviews). Can this be clarified?

The phrasing of the question depends upon the mother's answers to this question working back from the 24 and 15 month interviews, respectively.

* If the child has a special need at 24 months (regardless of whether or not one was reported at 15 months) ask:

> "I see at our previous interview you indicated that you had been told CHILD had (SPECIFY SPECIAL NEED). Has this diagnosis continued?"

* If the child did not have a special need at 24 months but the mother did report one at the 15 month interview, ask:

> "At 15 months you were told that CHILD had (SPECIFY SPECIAL NEED), but that at 24 months doctors said that was no longer the case. Since CHILD turned 24 months old, has a doctor or other medical professional told you that CHILD has special needs (that is, that CHILD has a condition or illness that restricts, or will restrict his/her normal activities, or that will interfere with CHILD's development)?"

* If no condition was reported at either 15 or 24 months, read the question as worded.

B. Section II of the 36 Month Standardized Interview

(1) Mother's Employment and School - Question #1: A discrepancy has been noted in the manual concerning getting descriptions of mothers' jobs. On page 66 the manual implies that interviewers only get detailed job descriptions for mothers if they have started a new job since the last contact. On page 91, however, the manual implies that interviewers are to get this information on all employed mothers, regardless of when they started their job.

Interviewers should get job descriptions for ALL employed mothers regardless of when they started their jobs.

(2) Mother Employment and School - Question #2: In the case of a mother changing her position title but not her employer (change code 2), where is this information recorded?

This information should be recorded (change code=2, title and new duties, occupation code, start date, and income) on the grid on page 4 called "Primary Job Information".

(3) Mother Employment and School - Question #2: One site had a mother who at 36 months was working for "ABC Rehab" as an occupational therapist, but then at 42 months was working for "XYZ Therapy" as an occupational therapist. It was the same job, with the same management, in the same location, but new owners. How should this be coded?

This should be coded as same job.

(4) Mother Employment and School - Occupational Coding: Should fast food manager positions be coded as category "1" or "8"?

If there is difficulty in determining whether a "manager' position belongs in category "1" or "8", and the specific occupation is not listed in one of the examples, probe to determine whether or not the mother is paid on an hourly basis or if she is a salaried employee. Managers on salaries should be coded as "1" and those on an hourly basis should be coded as "8".

(5) Mother Employment and School - How should interviewers code mothers who work one hour each month?

Do not record any work hours for mothers who work less than one hour per week on average.

(6) Mother Employment and School - Question #8: Does this question apply to secondary jobs as well as primary jobs?

This question may be asked in relation to a secondary job as long as there has been no change in the mother's primary job. If a mother has stopped both a primary job and a secondary job, ask this question only in relation to the primary job.

(6) Husband/Partner Employment and School - Questions 17 - 20: How is the husband/partner's work situation coded if he is on workman's compensation?

The husband is not considered to be working for pay so question 17 would be coded as "No". Do not record his income from workman's compensation in question 18, but it should be included in the family income question (Part 6, Que.30).

C. Part 6: Updating Our Files (Form 39C)

(1) Question 1: One of the RAs had a question about how to code a mother's response when she says that she usually takes her child to two different places for routine care.

In the case of using more than one place of routine care, code just one answer. Try the following special prompts when the parent names two places:

- Try repeating the question with an emphasis on ROUTINE care.
- Define routine care as, "for example, where you go for well-child care or check-ups instead of where you go when the child may be sick".
- If the answer is still two places, ask which type of a place she would use most often if the child were not sick.

If the mother is still insistent that there are two places that she takes her child for routine care, then the answer to question 1 should be "No".

(2) Question #2: Should the answer "doctor's office" be further probed to determine if the mother is using this doctor's office as part of an HMO plan (i.e. to distinguish "doctor's office" vs. "HMO/Prepaid group")?

Do NOT probe a mother's answer if she answers "doctor's office". Just take what the mother says. The intent of this question is simply to determine that a mother does have a particular place to take her child for routine care. The issue of whether the mother's doctor is part of an HMO plan is not important in this question. We will get this information later in Question #16.

(3) Question #3: How should you record the mother's answer when she says that she has a particular place to take her child when s/he is sick and another place she usually takes her child when s/he is injured?

The intent of this question is to determine whether a mother uses different places for routine and sick care. For example, mothers who use community clinics for routine care are often sent to outpatient clinics in hospitals or to emergency rooms for sick care. This question is NOT intended to capture mothers who use a specific place for routine and sick care but takes her child to a particular emergency room when injured.

To resolve the ambiguity in the wording of the question, the phrase "or injured" should be DELETED from the question. Please have your interviewers immediately delete the phrase "or injured" from the question on all copies of their forms so that Question #3 should read:

> "Now I will ask you about CHILD's visits for health care when CHILD is sick. Is there a particular clinic, health center, hospital, doctor's office or other place that CHILD usually goes to when CHILD is sick?"

(4) Question 6b: We have a lot of mothers who say they don't know if the office person knows about the child's medical history, but they do give the mother advice over the phone. How would this be coded?

The intent of this question is to get at continuity in the use of a health care source versus episodic visits to different locations or emergency rooms. Because the office person has access to the child's medical records, the answer would be yes.

(5) Question 15A:

a. When there is a category for an illness as well as a category for a symptom of that illness, do interviewers mark both? For example, what if a child has a condition with persistent bowel trouble and one of the symptoms is diarrhea. Or what if the mother reports that her child has both a skin and food allergy, i.e. that the food allergy causes the skin to break out?

If a mother reports that one of the conditions listed on page 5 is a symptom of another condition listed on page 5, mark BOTH and complete separate Health Conditions Follow-Up Pages (Form 39C-a) for both.

Be sensitive, however, that mothers may feel like they are answering the same follow-up questions twice. Be sure the emphasize to the mother that in one case, the questions refer to the consequences of the general condition (i.e. persistent bowel trouble), and the other questions refer only to the consequences of the particular symptom (i.e. diarrhea). If the mother says that the consequences of both the symptom and condition are synonymous, simply confirm her answers to the follow-up questions as you are probing the second condition.

b. Does the condition identified need to be doctor diagnosed? For example Mom reports child having pneumonia but doctor had not confirmed.

No, the condition does not need to be diagnosed by a doctor.

c. Would a digestive allergy include a reaction to a medication?

Yes.

d. Does a skin allergy include diaper rash?

Yes.

e. Some mothers have asked what interviewers mean by "frequent" in the health conditions (i.e. frequent ear infections). Since this is not defined in the manual, interviewers should tell the mothers, "That is not defined for me here. Please answer as you think is most appropriate."

(6) Question #25: How is the husband/partner's employment situation coded if he is on workman's compensation?

Code as if the husband/partner was unemployed. Then in question 25b, record the date that he was last at work.

(7) Question #29: When verifying the My Finances data what do you do when the mother says that the income amount reported in Q6 was incorrect? Some mothers even answered "No" to Q5 but then went ahead to list an income amount in Q6. What should be done about this discrepant information?

If a mother reported any income in Q6, but answered "No" to Q5, still verify the income amount with her. If the mother says that she did not have any income from these sources, write "No income" in the space provided.

If a mother reports that the income category she provided was incorrect, write "Incorrect data" and the letter of the new category corresponding to the MONTHLY income from these additional sources.

(8) Question #30: Should income from the partner be counted even if he is not currently living in the home?

Yes, include ALL sources of income that the family had in the year 1993, even if these sources are no longer available.

(9) Question #30: If a mother responds to this question by saying exactly $5,000.00 what skip pattern should be followed?

Follow the skip pattern for $5,000.00 or less.

(10) Question 30: Some sites reported that some of their mothers feel embarrassed by this question and requested that they be able to use the card each time they ask the question.

To be consistent with how income information has been reported in other studies, it is critical to ask the question as it is worded, without the use of a card. The card should only be used in cases where mothers refuse to answer the question. Other researchers who have used this question have found mothers to be willing to report their income outright. An important contributor to the mother's comfort in answering the question may be the interviewer's comfort in asking the question. Please reassure your interviewers that asking this type of question is standard practice in many research studies.

(11) Question #35: If the mother answers "yes" to question 33 and in 33b mentions two people as speaking the foreign language equally often, how is question 35 coded?

If a mother answers this question initially by saying two (or more) people speak equally often, first try saying, "I can only record one person here and then I have a question here to ask you in reference to that person. Please tell me who you think speaks to the child most often in another language."

If the mother is still insistent that two people speak to the child equally often, you can probe by saying, "Does one of these people spend more time with CHILD each week?". If the mother says "yes", ask question 35 in reference to that person.

If the mother is still insistent that two people spend equal amounts of time with the child and spend equal amount of time speaking to the child in another language, just randomly pick one of the two (or more) people mentioned.

D. General Questions

Some sites reported that it is awkward to have home visitors confirm each other's visits and that in the past mothers have not revealed information about their employment or child care status during these calls. They asked whether their visitors could confirm their own visits.

The purpose of this suggestion in the manual was to avoid having mothers reveal child care or employment information before the Bracken was administered. Sometimes, for example, confirmation calls are made to the mother's work number. If it has been your experience that mothers do not reveal this information during the confirmation call and when and where you make the call does not reveal this information, then it is fine to have your home visitors confirm their own visits. If this information is somehow revealed to the visitor prior to administering the Bracken, please remember to note this on Form 39X.

E. Health Condition Follow-Up (Form 39C-A)

For question 6a, if the mother answers "Never", do not ask question 6b.

II. Questions and Answers Regarding the Home Visit Questionnaires

A. "What Employment Means To Me" (Forms 3D & 3E)

If a mother is working less than ten hours a week, which questionnaire is the mother to fill out - "What Employment Means To Me" A or B ? The manual states that visitors use "What Employment Means To Me (Version A)" for all working mothers, including part-time, full-time and temporary work. Version B is to be used "for all others". The confusion lies in the fact that the "Combining Work and Family" questionnaire is administered only to mothers who are employed more than 10 hours a week. Should it be assumed that these two questionnaires are not consistent with each other?

It is correct to assume that these questionnaires are not consistent with each other. "What Employment Means To Me (Version A)" is to be administered to ALL employed mothers regardless of the number of hours they may work.

Please also note an error in the manual in regards to the employment questionnaires. On page 116, the manual states that the decision to use either version A or B of the "What Employment Means

To Me" questionnaire depends on the mother's work "in the last year". This is incorrect, this decision should be based solely on the mother's employment status at the time of the 36 month interview.

B. Love and Relationships (Form 3I)

Home Visitors wanted to know if it would be possible to move Form 3I from Questionnaire Packet #1 to #2. There has been a couple of cases in which the Home Visitors did not know that the father/partner had (recently) moved out of the home until after the mother had already filled out the form. Since this information is usually discovered in the Standardized Interview, which comes between Questionnaire Packets #1 and #2, would it be possible to move the 3I to Packet #2?

For now please leave Form 3I in Packet #1. If you find out during the interview that the father/partner no longer lives in the home, do NOT send the completed Form 3I to the DCC. Please check your data files to make sure that you have NOT sent Form 3I to the DCC for a mother who did not have a husband/partner currently living in the household.

C. My Finances Questionnaire (Form 15H)

(1) Question #5: Some mothers have NOT been reporting income from AFDC even though they are receiving public assistance. For example, at one site this public assistance is known to the mothers as "DPA", and they have recorded it under "other". Because a critical measure of poverty status in our study is whether or not the mother receives some form of public assistance in the form of cash, it is imperative that sites are indicating it as Aid To Families With Dependent Children and not as "other" income. If mothers at your site know AFDC by another name (or receive assistance in the form of cash from some other public agency), it is important that you write in this name on the questionnaire NEXT TO the AFDC option. These forms cannot be printed again so you must fill this in on ALL of your questionnaires by hand.

(2) Please note that in the manual on page 103 there is an error in regards to the Family Finance questionnaire. The manual says to highlight the word "Monthly" in question 6, however it is actually question 5 in which "Monthly" should be highlighted.

D. Post Home Visit Interview (Form 15Q)

(1) Questions 8 and 9: If the mother is working out of her home and is available to her child, or is without set work hours,

should questions 8 and 9 be coded?

If the mother is working out of her home do not code questions 8 and 9.

(2) Questions 8 and 9: Should mothers who work very randomly (once or twice a month) be coded?

If mothers work occasionally do code questions 8 and 9.

CHAPTER 28

Section 4

INFORMATION REGARDING THE 36-MONTH STANDARDIZED INTERVIEW AND QUESTIONNAIRES

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Chapter 28

Section 4

INFORMATION REGARDING THE 36-MONTH STANDARDIZED INTERVIEW AND QUESTIONNAIRES

I. OVERVIEW

The administration of the Standardized Interview and Questionnaires is designed to occur during the 36-month home visit. Questionnaire Set I should be completed by the mother while the Visitor administers the Bracken Basic Concepts Scale to the child. The HOME should be administered after the Bracken with the Standardized Interview and Questionnaire Set II following after the HOME is completed. This preferred order of administration may be changed, if needed, in accordance with the general guidelines for conducting the 36-month home visit described in Chapter 28, Section 1.

The Standardized Interview and the Questionnaires are designed to collect specific information from all mothers in a systematic form using objective techniques and measures that have been used in other studies. By collecting data in this way, these data can be compared to other data from families in previous and future studies. It is important to follow all guidelines listed in this manual.

The purpose of the Interview at 36 months is to collect information about any changes that may have occurred in the family since we last spoke with them at 33 months or, in some cases, since we last visited with them at 24 months. Mothers in the study were asked questions similar to these when their babies were 1, 6, 15 and 24 months old and again, on the phone, at tri-monthly intervals. Before you interview the mother when her child is 36 months, you will need to review the family's files from these previous interviews and you will need to enter information in the appropriate places on the 36-month forms.

The Standardized Interview is made up of three sections. Section I of the Interview (Form 15A) consists of Parts 1 and 2: Part 1 asks about changes in household data, and Part 2 asks about family health and recent life events.

Section II of the Interview (Forms 15B and 39C) consists of Parts 3, 4, 5 and 6. Part 3 asks about changes in the mother's employment or educational status, Part 4 concerns the partner's employment or educational status, Part 5 asks about feelings and attitudes about employment, and Part 6 asks further questions regarding family socio-economic status, non-english speaking situations, and living arrangements. (Note that Parts 3, 4, and 5 are included on Form 15B; Part 6 of the interview is on Form 39C.)

Section III of the Interview consists of several different procedures. First, interviewers will check over the questionnaire data to make sure the mother has not left anything blank. They will also complete the Questionnaire Log if they have not already done so. Second, they will explain the ear infection data collection procedures and obtain physician's names. Finally, interviewers will update addresses and phone numbers for the family and contacts.

The ideal order of administration of the interview and questionnaire portion of the home visit is as follows:

1. Questionnaire Set I while child completes the Bracken.
2. Interview Section I.
3. Interview Section II.
4. Questionnaire Set II.
5. Interview Section III.

The order of administration can be modified to suit the particular circumstances of the home visit as is necessary. For example, mothers may not want to complete the Questionnaire Set I during the Bracken. These could then be completed between Sections I and II of the Interview. See Chapter 28.1 for more guidelines about varying the order of procedures during the Home Visit.

II. THE INTERVIEW AS A SOCIAL SITUATION

Interviewing is a social interaction, a form of structured conversation that calls upon everyday social skills such as tact, attentiveness, and courtesy. In a standardized interview, the interviewer has a schedule of questions to be asked of the interviewee in an organized, structured manner that is the same across all interviews. Likewise, standardized interview questions are designed to be administered to all subjects in exactly the same ways.

A successful standardized interview depends upon the interviewer's attention to two major concerns: (1) establishing an appropriate context for the interview, and (2) minimizing interviewer-related error in the data collected. In this section, we discuss some general principles as to how an Interviewer can address these concerns. Some of our comments are taken from Chapter 7, "General Instructions," for the HOME. Other comments are taken from the IHDP Phase II Assessment manual. Comments regarding specific interviewing techniques and the minimization of interviewer-related error are taken from Fowler Jr., F. and Mangione, T. (1990) Standardized Survey Interviewing: Minimizing Interviewer-Related Error. Sage Publications, Applied Social Research Methods Series, v. 18: Newbury Park, CA.

A. Establishing a Context for the Interview

This interview should be one component of a pleasant 36-month home visit with the mother. It should take place in a comfortable and private place, where there is little opportunity for interruption or disruption. Mothers should feel assured that whatever they say will be heard only by the Interviewer (and possibly the child and the childminder) and will be totally confidential.

During the interview, the child may be engaged in play nearby. To minimize distractions from the target child or other children in the household, sites may have arranged for childminding. Removing the child (or children) from the area immediately surrounding the mother can help minimize distractions. The arrangements for engaging or watching the child should be made with sensitivity and tact. Only after consulting with the mother and receiving her permission for any planned childminding activities should the child minder begin the actual process of minding the child. It is the mother's home. She, not we, are in charge.

Before the interview begins, the interviewer will already have said several positive things about the mother's participation and about the child. If not, this is a good place to do so.

As much as possible, have the interview sound like a conversation. Because it is a structured interview, a conversational style is not always easy to achieve! Being totally familiar with all questions and all procedures will help you avoid fumbling with materials and awkward hesitations. Establish a relaxed posture and pace. Maintain eye contact to the greatest extent possible and listen carefully to everything the mother says.

You want the Interview to be a comfortable experience for the mother, but an interview is more than just a friendly conversation. Interviewing is a professional job. It requires professional skills. The tone of your voice will convey your professionalism and self-assurance. Express genuine interest in what the mother tells you. Questions should not be approached in an apologetic or embarrassed manner. The questions have been used before, many times. Mothers have not found the questions to be too personal or difficult. Many mothers say they enjoy the experience of the interview and questionnaires. They say it helps them think about things they had not considered before.

Show interest and positive attention to the mother. Look at the mother as she answers. Acknowledge her responses with a nod or a smile. Don't just look down for where to record the answer. Carefully avoid using statements such as "That's fine" or "Good" after the mother completes an answer. These seemingly innocuous statements may subtly reinforce particular types of answers. If you feel you need to say something to the mother to assure her she is doing her part in the Interview or just to maintain a comfortable flow to the interview you might say something like, "You're answering my questions very clearly," or, "You're making my job very easy."

The quality of your interview is critical to this study. Your approach is key in determining the quality of the data we obtain!

B. Neutrality and Confidentiality

Maintaining a neutral attitude toward the mother's responses is important. Avoid behavior that could affect how the mother answers. For example, do not suggest answers to the mother and do not reword or interpret questions for the mother, except in accordance with the specific guidelines described in this manual. Do not anticipate answers to questions.

Avoid giving your opinion, even if asked. When responding to questions about the study, refer to the information we give the mother about the study in the brochure, in the two-week phone call script, and in the Informed Consent. Keep your answers short and concise.

Do not let your tone or the pace at which you read questions indicate that one answer is preferable to another. For example, do not read some response options faster than others or with more vocal inflection than others.

A mother should feel free to speak candidly. In order for her to speak candidly, we guaranteed her (in the Informed Consent Form) that all the information we collect about her and her family will be confidential. We guaranteed that all data will be kept confidentially, in a locked file cabinet. If you cannot keep information confidential (such as in a case of child abuse), you should stop the mother and explain to her the limits of your promise of confidentiality before allowing her to continue. Preserving confidentiality also means that you discuss data only with NICHD project staff and that you do not conduct interviews with families with whom you are otherwise acquainted.

C. Informing the Mother of Her Role

The key to a successful interview is "training the respondent" (Fowler and Mangione, 1990). The interviewer should let the mother know what is expected of her during the interview. Direct instruction should be provided at the beginning of the interview, but instructions are rarely sufficient. Expectations are also conveyed by modeling, careful listening, and by giving the mother feedback about the appropriateness of her responses throughout the interview. Remember, being a respondent is hard work. The mother must listen carefully to each question, then give her answer in the form required. For example, the mother must learn to fit her answers into coded response categories even when her most natural answer might be "it depends."

Immediately before beginning the interview questions, tell the mother what you will be doing and what you would like from her. Also feel free during the course of the interview to "step out of the interview" to "train" the mother when necessary. Mothers are likely to feel most comfortable with the interview situation when they know what we want from them.

Positive reinforcement. Most of our mothers have been through the process of the Interview and Questionnaires several times before. Thus, they should generally be familiar with how they should respond to questions and with their role as a respondent. Nonetheless, when a mother responds appropriately to a question, provide positive reinforcement. This can take the form of a word or a gesture to let the mother know that this is the type of behavior you expect. Phrases such as "Thanks," or "Yes, that's what I meant," are all good examples of positive feedback. You can also reinforce the mother's behavior by nodding, smiling and writing down her comments. How much feedback to use depends on your respondent. Since most have been through the Interview several times, they should re-learn their role quickly and require only periodic feedback. A few may need to be reinforced every time they make an appropriate response. Be extremely careful, however, not to just reinforce certain types of answers. Remember, you are reinforcing answering behavior, not the content of her answers.

Digressions. There are some behaviors you want to be especially careful not to reinforce. An interview can continue for a very long time if you allow the respondent to tell you a story while answering each question. If a mother elaborates on something when you really only need a brief answer, say something polite like, "Yes, I see what you mean. I think I've got what I need here". A long digression can be halted by saying things such as "That's interesting. Let's finish the interview and then we can talk more about this later". Such a statement not only explains why you are there (i.e., to interview her), but also communicates to her that you are interested in her as a person. Since this isn't an open-ended interview (although some questions do allow for more open-ended responses), this probably won't be a big problem, but you don't want people to feel cut off. This must be handled delicately.

Interruptions. It is important that the mother hear the entire question and all the response categories before answering. Her answer may change after she has heard all the possible answer choices. If the mother tries to answer before you finish reading a question, gently let her know that she needs to hear the entire question before selecting an answer. You will also want to re-read the question to her if she interrupts during the question. If she interrupts during your reading of response choices, just re-read all of the response choices to her. If its been a lengthy interruption, re-read both the question and all the response options.

If a mother starts giving you answers to questions that will be asked later on, let her know you will be asking about that topic later. You may also want to let her know you have to ask the questions in a prescribed order. It is better to stop her politely than to have her go through the information twice. Try to maintain control over the administration of the interview.

During the pilot visits, RAs noted that the study child was frequently the source of interruptions during the interview portion of the visit. If your site knows that a child will need a lot of attention, it may be advisable to bring along a childminder just for the target child. The Visitors could also bring along some attractive, age-appropriate toys to occupy the child during the interview. Many of the interruptions may not be preventable so the interviewer should remain patient and help the mother answer the questions as easily as possible. If, for example, the mother is interrupted before she can answer a question, re-read the question to her. If the mother is being asked a series of questions when she gets interrupted for more than a minute (for e.g., those pertaining to her employment situation or her child's awakenings in the past week), set the stage again for her. You may remind her of a few of the previous questions and her responses. Then you may lead in with the question where the interview got interrupted. For example, say something like, "We were just discussing your child's awakenings at night in the last week. You said that your child has awakened at night two nights in the past week. About how many times each night did CHILD awaken?".

Interviewers may also find themselves having to interrupt the administration of the Interview or Questionnaires because the child woke up after initially being asleep at the start of the home visit. When the interview is resumed later in the visit, make sure to set the stage again before going on to ask particular questions. If the mother gets interrupted in the middle of a questionnaire, ask her to look over the instructions again as well as her previous answers when she resumes filling out the questionnaire.

D. Pacing

Pacing is one way the interviewer gains control over the interview situation. Establishing a good pace does not mean reading questions in a monotonous fashion. Questions should be read at an approximate rate of two words per second. Don't pause between every word, but between word phrases.

When the pacing of questions is slow and even, mothers answer more thoughtfully. As a result, you won't have to repeat questions as often. The mother will set the pace of the interview from information and cues provided by you. A slower, more leisurely pace will allow you to work carefully and to follow skip patterns and other interviewer instructions. Proper pacing can also reduce tension for you and the mother. Deliberate, even pacing is important because an uneven reading of questions or response categories can bias the respondent by suggesting that some responses are more important than others.

E. Sharing Personal Information With the Mother

Even though you should try to establish a conversational tone, take care to avoid sharing personal information. If you share such information, you may inadvertently establish certain response biases in the mother as she assesses what your values may be. The validity of the data depend upon the establishment of an interpersonally neutral atmosphere. Making evaluative statements after the mother answers a particular question or sharing personal information with her are two major ways an interviewer can introduce bias into the data collected.

F. When a Mother Reveals Her Personal Problems

Occasionally, in a mother's eagerness to talk, she will make an appeal for help with her own personal problems. Sometimes, mothers talk for so long about their problems that there is not time to attend to the interview. (See earlier comments about digressions.) As an Interviewer you should not feel it is your responsibility to handle these problems or to solve problems for the mother. You might say something like *"I can understand your being upset (or concerned) about that. When we finish discussing the interview, we can talk about it more."*

Researchers at each site should be familiar with the services that are available to parents in their area. If a situation arises in which a mother requests information or some type of referral, you may say something like, *"I can see that you would like help. I am not (trained) (in a position) to help you, but perhaps you would like me to talk with Dr.----, our Director, and s/he will know of someone that could be of help to you."* Immediately after the visit is completed, document the mother's concerns and requests on the Interviewer Report Form (see Appendix B) and discuss the situation with your Study Coordinator and/or Principle Investigator. Get back to the mother as promptly as possible with the appropriate information. If it seems appropriate to have your PI or SC speak with the mother, the Visitor should ask if the mother would like the Director to call.

Each site should keep a record of the kind of information distributed to a particular parent and what impact, if any, this had on the family's life, if known. (This can also be recorded on the Interviewer Report Form.)

III. MINIMIZING INTERVIEWER-RELATED ERROR

The preceding section dealt with how to establish a friendly yet interpersonally neutral context for conducting the interview. This section contains in formation on specific interviewing techniques designed to minimize interviewer-related error in data collection. It is impossible to eliminate error entirely. However, by following the techniques outlined below as closely as possible, interviewer-related error should be kept to a minimum.

A. Standardized Interviewing Techniques

1. Read Questions Exactly as Written

Reading the question exactly as written is critical to maintaining standardization across all ten sites. If the wording of questions is changed by interviewers in even the slightest way, the researchers can never be entirely sure what question the mother was answering.

There are rare occasions when exceptions are allowed. Sometimes reading the question exactly as worded compromises rapport. When the interviewer believes this will happen, she may rephrase the question as a confirmatory question by altering the standard order of words in the question. For example, based on initial piloting with the protocol, several interviewers felt silly or awkward asking the mother, "Are you breast feeding

BABY?," when the mother was actually breast feeding at that moment. In such situations the Interviewer may rephrase the question in a confirmatory manner: "And you are breast feeding BABY?" is perfectly acceptable in this situation. When confirming, remember to use all of the meaning-containing words in the original questions. For example, to confirm employment do not say, "So you are now working," or even "You are employed." These two confirming statements could potentially alter the meaning of the question. Do say, "So you are now working for pay." Using the exact words of the question.

While asking a confirmatory question may seem unnecessary in the breast feeding example, most other questions are not that clear cut. The HABIT of confirming ensures that no question is accidentally skipped.

Another occasion when a confirmatory question is allowed is when the observer already knows the answer. For example, it often occurs that the interviewer has already learned that the mother/father is self employed prior to the moment in the interview where this question is supposed to be asked. Following the guidelines above, there are two acceptable ways this situation can be handled. These are illustrated below.

Interviewer A said, "Sometimes we have a question which doesn't exactly fit the situation, but I need to ask you just for the record. Who is his employer?" She reports that so far, she has not had any mothers who seemed offended by even the most obvious questions. She feels that these types of shared awkward situations serve to build rapport, because it reminds the mother that both the interviewer and mother are engaged in a joint task.

Interviewer B, on the other hand, simply said, "And he is self employed?" Both approaches are considered acceptable. Which approach is selected depends on the interviewer's style, the mother, and the specific situation.

Interviewers need to be prudent when deciding to use confirmatory questions since changing questions can easily increase interviewer-related error in the data.

2. Avoid Offering Interpretations of Questions, Words, or Phrases.

Unless every interviewer uses exactly the same alternate phrasing or definitions, offering interpretations or definitions introduces unknown variability into the procedures. However, getting complete data and maintaining rapport sometimes requires providing assistance to the mother. You may occasionally have to clarify a question or define a word when a mother is unfamiliar with the vocabulary. There are several situations when this may occur.

a. If a mother asks for clarification of a word or the meaning of a question and this has been defined in Sub-Sections IV or V of this chapter, you may rephrase the question using the given definition or give her the definition to help her answer the question. For example, if the mother asks, "What counts as separated?" in regard to marital status, you can tell her that it means that she is married but that she and her husband are not currently living together by choice. It is important that interviewers brush up on these definitions by reviewing the information in Sections IV or V on a regular basis.

b. If the mother asks for a definition of a particular word, the interviewer may give one in certain cases even if it is not defined in Sections IV or V. If the mother simply does not know the meaning of a vocabulary word, you may offer her the definition. For example, if a mother does not know what a "tantrum" is, you can tell her that it means a fit of bad temper (dictionary definition).

An interviewer may NOT define the meaning of a word or phrase for a mother when the word is, or the phrase includes, an adjective or adverb. For example, if the mother asks how you would distinguish good or excellent health, you may not define this for her. Another example is if the mother tells you she is usually very satisfied with her job but occasionally she also experiences dissatisfaction and then asks, "Would that be somewhat satisfied?", you should not answer the question for her. In addition, you are not allowed to define terms like "Mostly false" or "has mixed feelings." A good rule of thumb is: do not define a term if there is even a small chance that the mother (or you) may define the term differently than intended based on subjective experience. Instead, you may say something like the following: "In this situation we're interested in what this word means to you. Let me repeat the question...."

When you do define a word for the mother, keep your definitions short. In our experience, the more explaining you do, the less likely you are to be effective. If you choose to define a term for a mother, record the definition you used on the Questionnaire Log (if it is a questionnaire item) or on the Interviewer Report Form (if it is an interview question). If you find that you frequently have to define the same word for different mothers, try to use the same definition. In addition, share this information with other interviewers at your site so that you can all be consistent in defining terms.

3. Determine When a Response is Acceptable

As the interviewer, you will determine the acceptability of a given response. In order to make this judgment, you must understand the mother's response. You must also be familiar enough with the information in Section IV to determine whether or not the mother has answered the question sufficiently.

If the response is acceptable, record the information given and move on to the next question. A response is acceptable if it answers the question using the given response categories.

If the response is unacceptable, you must determine why. It may happen because a mother answers in prose form and did not use one of the precoded response categories. Or, the mother may not have heard the entire question or may not have understood what was being asked. If you think this is the reason behind her unacceptable answer, re-read the question, emphasizing key words that convey the meaning.

Frequently, an answer is unacceptable because it does not fit into existing response categories. In this situation, the interviewer needs more or different information from the mother and therefore, probing is required.

4. Always Probe Non-directively

Probing means asking questions. Nondirective probing is asking questions in a way that does not prejudice the mother in any way but allows her to offer you an acceptable response.

Probing is used to re-focus the mother's attention on the available answer choices. For example, when a mother responds, "It depends" or "Somewhere between this category and this one," you need to preface your repeat of the question with a remark like, "Which comes closest..." or "In general..."

a. Probing closed questions. If a mother rephrases a response category, do not record the answer you think comes the closest. Instead, ask her to select one by saying something like, "Which one of these answers comes closest to yours..." When you re-read the response categories, make sure you read all the available choices. You do not want to narrow the choice for the mother by reading only the choices that are closest to her original statement.

b. Probing numerical questions. When probing for numerical responses, interviewers should take exceptional care not to lead respondents. Never ask a question that can be answered yes or no. Never suggest a particular range where the answer may fall. The simplest approach is to tell the mother you need to get a specific value. If she says she can only estimate, reassure her by stating something like, "We would like it if you would make your very best estimate. Even though it may not be exactly right, no one is in a better position than you to make this estimate. Do the best you can."

If a mother offers two numeric answers which are both possible response categories, simply ask her, "Which answer comes closest to how you feel/your experiences, etc.?"

c. Probing open-ended questions. To probe responses to open-ended questions, the following three probes may be used. "How do you mean that?" is used when the respondent provides an unclear response. "Tell me more about that" is used when the answer is incomplete. "Anything else?" is used even when a seemingly appropriate answer is given to make sure that additional points the respondent wants to make are heard. If a mother simply does not answer the question, repeat the question.

d. Probing "I don't know" responses. "I don't know" responses need to be probed. The first job of the interviewer is to determine the origin of the respondent's problem. The answer "I don't know" can indicate several things. Sometimes the best probe is the silent probe. If a mother appears never to have thought about the issue before, you may find simply waiting expectantly for an answer produces good results! Sometimes you may need to encourage her to think about it for a second, reminding her that she is uniquely qualified to provide information on this topic. You may want to say, "I wonder if you could take a minute or two to think about it," or: "We are just interested in your opinion." If "I don't know" is given because a mother is unsure about the quality of the answer, remind her that there are no right or wrong answers to these questions and that we are interested in what she thinks.

If "I don't know" seems to reflect that the mother genuinely doesn't have an answer, it should be recorded as a "DK", and the response grid left blank. However, to be sure this is the case, you need to probe all "don't knows" at least once. The purpose of a probe on a "don't know" answer is not to force the mother to answer if she doesn't know the answer, but to give her a chance to think about her response.

B. When the Mother Gives you Contradictory Information

If a mother gives you information which contradicts her earlier answers or contradicts information you gathered outside the interview, you need to ask the mother for clarification. For example, you might say, "I'm a little confused here. Earlier when we were discussing (fill in the blank) I recorded (blank). Am I missing something important here?" If the interview has already ended, the interviewers should feel free to bring out the interview forms and re-ask the appropriate questions. Before taking out the interview forms, you may want to first probe non-directively, (e.g. "Can you tell me more about that?") to get the "big" picture so as to be sure to cover all of the relevant questions again.

However, you may only ask the mother for clarification concerning factual information or confusing statements she has made to you. If you think the mother's answer is inconsistent with something she has already communicated to you, you may re-read the question. However, be careful not to compromise rapport. Do not re-read a question on those occasions when the mother's answer just seems inconsistent with appearance (e.g. income is too little or too much given household appearance; mother says she is fine when she appears to be in considerable distress) or when you believe the mother is, for whatever reason, not being truthful in answering the question. Such data errors will have to stand as reported by the mother.

C. When You Are Having Difficulties

Never use your own discretion in choosing answers for the mother. If the mother does not choose a category and your non-directive probing does not help, it is sometimes helpful to "re-train" the mother for her role as interviewee. Explain to her that this question has pre-determined categories and that you need her to give the answer which most accurately reflects her situation. Rapport, however, should not be compromised.

If you feel it would be pushing the mother to repeat a question or to train her, treat her response as though it were to an open-ended question and write down verbatim what the mother has said. After the visit is completed, you will want to discuss how to code her response with other interviewers, your study coordinator or your PI.

The following is a specific example of how to re-train the mother. It is based on an actual pilot mother.

I:	(Question 18, Int 2a) "How would you describe your health compared with other women your age? Would ..."
S:	"Good."
I:	"This is one of those questions where I have a list of responses. I'd like to read you the list so that you can choose the one that fits your situation best."
S:	"O.K."
I:	"How would you describe your health compared with other women your age? Would you say your health is poor, fair, good, excellent?"
S:	"Excellent."

D. When Mothers Have Negative Feelings About the Interview

Not all mothers will like every question. If a mother expresses negativity about a particular item, accept her opinion. Do not convey the impression you think the question is stupid, trivial or offensive. You may want to say something like, "Some questions may not seem relevant to you or your lifestyle. Because this is a national study, we will be seeing many different types of families. For some families, this may be a relevant issue.

Please answer the question as best as you can." If she seems offended by a question, supportively remind the mother she can refuse to answer any question she wishes to.

E. Exercises

The following exercises have been taken from the IHDP Phase II manual. Each exercise will emphasize a different type of interviewer skill. Try to answer each question listed as per the specifications of this manual. The answers follow.

Exercise 1:

Interviewer: Over the past few weeks, would you say that (child) is:

1) Not clinging, can easily be left with people (s)he knows
2) gets upset if away from you but gets over it, or
3) is very clinging; can't be left with others

Respondent: I don't know--she seems to act differently with different people. Usually, when I leave her with my mother, she's fine.

But sometimes when I leave her with the babysitter she gets really upset.

Interviewer:

Fill in response here:

- -

Exercise 2:

Interviewer: For each statement I read, please tell me whether (child) acts this way rarely or never, sometimes, or almost always?

(Child) is worried about not getting enough.

Respondent: What do you mean by enough? Enough what? Toys, food, hugs?

Interviewer:

Fill in response here:

- -

Exercise 3:

Interviewer: (Child) can't concentrate, can't pay attention for long.

Now in the last 6 months, is that statement very often true or often true, somewhat or sometimes true, or as far as you know, not true?

Respondent: Well normally she is pretty good about playing by herself for a long time. But in the last few days or so, she seems to get frustrated with all of her toys.

Interviewer:

Fill in response here:

- -

Exercise 4:

Interviewer: A child's success at school depends on how much his mother taught him at home. Do you: strongly agree, agree, disagree, or strongly disagree?

Respondent: I don't know; none of my kids are in school yet, so I don't really know.

Interviewer:

List steps for probing this answer.

- -

Answers to Interviewing Practice Exercises

Exercise 1:

The goal of this exercise is to provide practice in "probing" to get the respondent to answer with one of the existing categories. The respondent has provided an answer that boils down to "it depends". She has not answered the question. When you get an answer such as this one, re-read the question emphasizing the words that will help her arrive at an answer. In this case, begin your re-reading of the question with the phrase, "in general" and emphasize the phrase, "over the past few weeks" to indicate that she is to generalize over that period.

Exercise 2:

In this case, the respondent appears to understand the question, However, she wants clarification of a common word which can have several interpretations. You should respond "whatever 'enough' means to you".

Exercise 3:

The mother is unclear on the time frame that you want her to answer within. Stress that the information you want is what the child was usually like, or what was generally true, in the last 6 months.

Exercise 4:

There are several specific steps that you should go through before recording an answer of "I don't know". You should first use a silent probe, i.e., wait expectantly for an answer. This will give your respondent a chance to think about her answer. If she still does not answer, you may say: "I wonder if you could take a minute or two to think about it." or "We are just interested in your opinion." Then re-read the question, emphasizing key words or phrases. If the respondent is still unable to answer your question, record "don't know" by writing "DK" in the response category area, and then an "X" in the left margin to indicate that you "probed" her answer.

F. Putting it Together: A Friendly Context and a Professional Interview

It may seem that using the standardized interviewing techniques outlined will sometimes jeopardize rapport. These techniques need not interfere with our goal to provide a pleasant experience for the mother. The context in which the actual interview is embedded, (i.e. what is said before, during and after the interview,) is most critical in setting a relaxed and friendly atmosphere. It is acceptable to "step out of" the interview at any time to maintain rapport. This is done by adapting to the mother's pace and to the things (i.e. the child) competing for her attention. In addition, interviewers should feel free to "train" the mother whenever is appropriate by explaining to her exactly what you need from her.

While all questions should be read exactly as written, except where noted above, no two interviews will be exactly the same because the total context of the interview will be different in each case. For the purpose of minimizing interviewer-related error, all that is necessary is that the actual interview questions be read as written, with minimal interpretation, and that the interviewer always probes in a non-directive way and avoids all evaluative feedback. As an interviewer your goal is to become so familiar with these techniques they become rote. In this way, attention can be devoted to listening to what the mother is saying and to responding to her concerns.

To establish and maintain rapport, it is also essential for you to be comfortable with administering the interview. If the wording of some questions seems awkward, practice saying the questions aloud until you feel comfortable with them.

Sometimes difficulties arise because the interview itself is not perfect. It is impossible to anticipate all the concerns families may have. It will be more difficult to administer the interview to some mothers than to others. At times, you may feel the information recorded on the forms does not accurately reflect the mother's circumstances. There are many unusual circumstances that confront families that the interview will not tap. The interviewer's job is to help a mother provide the best information to the questions as they are given. Important information that is not included in the interview may be entered into the Interview Report Form. Also, remember that we will be updating our information every three months. So, don't worry if recent changes in family circumstances as reported in the interview do not fully reflect the family's more general situation. We will find this out in later assessments.

In conclusion, the most important job of the interviewer is to establish good rapport with the mother. In those cases where the mother does not appreciate your objectives as a researcher and is not responsive to your efforts to establish rapport while maintaining standardized interviewing techniques, bend the rules as necessary to maintain rapport. (Indicate what you did on the Interviewer Report Form!) Through piloting we have discovered that most mothers are willing to cooperate with the interviewer and to do their best job to be a "good" respondent.

IV. ADMINISTERING THE STANDARDIZED INTERVIEW

A. Purpose of This Section

This section provides specific information about the questions included in the interview portion of the 36-month home visit. In addition, this section will serve as the archival description of the way in which interview data were collected.

It is vital to the success of the NICHD Study that the basic format and content of every 36-month interview be standardized. Please refer to other sections of the Operations Manual for the 36-Month Home Visit for specific instructions regarding the way the interview is to be conducted.

This portion of the manual will be modified, if necessary, during training and data collection. Any suggestions for additions or amendments should be addressed to Marsha Weinraub at the Temple site and Bonnie Knoke at the Data Coordinating Center.

B. Things you may need

Things you may need for the 36-month Standardized interview include: a writing board (not a clipboard; it may wrinkle the pages), pencils (no. 2), extra interview and questionnaire forms, the operations manual for reference, response cards, an envelope in which to place the completed questionnaires, a large self-addressed stamped envelope for returning any forms to the site office, cash or check for parent, a receipt for parent signature, an audiotape recorder for reliability taping, extra audiotapes and batteries, and postcards to notify the site office as address changes occur.

C. Format of the 36-Month Interview

Every interviewer needs to become thoroughly familiar with the format, layout, and questions of the 36-month interview. Because family situations differ in so many ways the questions are constructed to cover a great variety of responses. Despite our best efforts, the questions will not suit every situation perfectly. There will be times when an interviewer will need to adapt a question slightly so as not to appear insensitive to a mother. To help you in making needed adaptions, we have provided alternate wording for some questions within the text of the interview script.

Within each section of the interview, there are a number of checkpoints which direct the interviewer to skip over specific questions or sets of questions because they are not relevant to a particular situation. It is important that the interviewer be completely familiar with these checkpoints so the interview can proceed smoothly.

The conventions followed in this interview protocol are:

1. The directions to the interviewer that are not intended to be read to the mother are printed in ALL CAPITAL LETTERS. The questions and comments to be read to mothers are printed in standard upper and lower case letters.
2. The interviewer should continue to the next question unless instructed otherwise by a GO TO or checkpoint instruction.
3. Questions designed to fit more than one situation are structured so that the choices between two wordings are in parentheses. Example: "How satisfied are you with your decision about (working/not being employed/going to school) right now?" The interviewer should choose the appropriate wording for the mother's particular situation, not read all options. Therefore, you need to understand the intent of each of these questions as well as the different possible situations to which each question refers. You must also be alert to the individual situation of the mother being interviewed.
4. Questions in which a person's name (or other specific personal information) is to be used indicate the nature of the information to be read by the interviewer in capital letters. The actual wording you should use depends on what the mother's name actually is (or on whatever other specific circumstances referred to in the question actually obtains for the family being

interviewed). For example: "In MONTH, when we last spoke with you, you reported a problem with ILLNESS. Is that still a problem?" The question should be read as, "In May, when we last spoke with you, you reported a problem with high blood pressure. Is that still a problem?"

5. Information in parentheses should be read to all mothers UNLESS the information does not apply to that mother's situation. (For example, in Section 1, page 12, item 4. Unless the injury was an illness from a poisoning, this phrase is not read. For a second example, in Section 1, page 13, item 26: If the mother and child are the only ones in the household, do not read the phrase in parentheses "(or anyone else in your household)". For a third example, in section 1 on page 15, item 33. If the mother did not previously report a health problem, do not read the word "(other)".)

1. Marking the Forms

The mark-sense forms used for the interview must be filled in carefully. Use a #2 pencil and be sure to blacken the entire space to indicate the mother's response. Whenever there are 2 columns of numbers, (as for month and day, for example), mark both columns. If your response requires only one digit, mark 0 in the first column.

For example, to record a date of February 1991:

MONTH		YEAR 199_
■	0	0
1		■
2	■	2
3		3
4		4
5		5
6		6
7		7
8		8
9		9

The blanks above the columns are for your convenience in recording mothers' responses. Often it will be quicker to simply write in the response, then fill in the mark-sense spaces later. This is especially true for complex questions that have several sets of responses, such as the household information.

When responding to a question, a mother may give you additional information that is not coded as a response. Nonetheless you may record the mother's response to demonstrate that what she tells you is important. You may write such information on the forms so long as you do not write over the mark-sense spaces. Be sure to keep your notes to the left side of the page.

Also, if it is not clear how to code a mother's answer, write all the relevant information on the interview to the left of the mark-sense spaces. Before you turn in the interview, discuss the coding with your site coordinator or principal investigator.

D. Interview Script

The interview data forms contain only a few brief sentences to introduce or to close sections. These are included to remind you to explain to the mother what is going to happen next. These explanations do not have to be read exactly as they are written; but it is important to inform mothers in advance about the general topic of the questions to come. Interviewers may phrase these introductory and transition sentences in their own words. Once you begin the questions, however, each question should be read exactly as it is written. The only exception to this rule is the occasional situation where the information requested is obvious or already known to the interviewer. In such cases, the interviewer may reword the question as a statement, confirming with the mother the accuracy of the information previously obtained.

Before beginning the actual interview, it is important to give the mother some general information about the way you will be conducting the interview and what your expectations are. To explain the purpose and format of the interview, say something like:

> "*During this part of today's visit, I'm going to ask you some questions about your experiences as a parent so far, and get an update on your family. I'll ask you some of these questions as part of our interview, (while others will be asked in the form of a few more questionnaires which I will ask you to fill out). Some of the things I'll be*

asking you are very much like what you have been asked before. That's because we want to know how things change or stay the same over time as your child grows. Please try to answer each question by telling me how you feel right now. This part should take no more than (45) minutes, OK?"

Note: Adjust instructions and the expected length of the interview depending upon whether you were able to complete Questionnaire Set I during the Bracken.

Explain interviewer's and mother's roles:

"I will be reading you a set of questions exactly as they are worded. This is so that every mother in the study is answering the same questions. I'll be asking you to answer two kinds of questions. In some cases, I'll ask you to answer in your own words. In other cases, I'll give you a list of answers and ask you to choose the one that fits best. If you have questions at any time during the interview, please be sure to ask me. ***And as always, all information which you provide us will be kept confidential."***

Mothers have different ways of responding to interview questions. Some are very precise and specific, while others tend to give vague responses or answer in general ways that are not codeable. You may encourage mothers to be more specific by enlisting them as partners in the process of data collection. For example, if a mother responds to the question,

"How long have you been living with (husband/partner)?"

by saying

"Since 6 or 7 months ago."

you can say,

"I can only record one answer. Would you say it's closer to 6 or 7 months ago?"

If the actual amount of time was somewhere in between, you can explain to the mother how we round up or down to come up with a single answer. The next time the mother responds with a range of numbers instead of a single answer, follow the same procedure. Usually after two reminders, mothers will understand the requirements of the interview and begin to give you codeable responses without prompting.

E. Pre-Visit Preparation for the Interview and Questionnaire

Prior to going on the visit, the Questionnaires need to be assembled into two packets containing Sets I and II. Make sure the questionnaires are put into the packets in the prescribed order (See Appendix C).

Information from previous interviews also needs to be entered onto the face sheets of the interview (see below) and on to the interview forms. **If at all possible, this information should be completed by someone other than the Visitor who will conduct the visit.** This arrangement will help ensure that the Visitor administering the Bracken is blind to employment and child care status before administering the Bracken.

Finally, the home Visitor will need to assemble information on the status of ear infection data collection for the family before going on the visit. Please refer to Chapter 28.5 for the appropriate forms which need to be completed before the visit and for which forms the Visitor needs to take with her on the visit.

F. Face Sheet/Interview Record

The front three pages of the 36-month interview form 15A are for use by the project staff at each site to help keep track of individual families. **These pages should not be sent to the Data Coordinating Unit**. Page 4 is the official record of the interview and should be included with materials sent to the Data Coordinating Unit.

In preparing for the interview, on the first face sheet, record the names of the mother and child plus the address and phone number of the family. The name of the interviewer should also be recorded.

On the second page of the interview forms, record the dates of previous contacts and the names of staff members who have visited with the mother. If the mother mentions someone or something that happened at a previous visit, it is helpful if you are able to identify the person who talked with the mother before.

In this interview you should only collect partner information about a live-in husband or partner. However, fill in the husband/partner or child's father's name (if known) on Page

2, so that you will have this information if the topic comes up during the interview.

At the 36-month visit, you will also need to check question 23 on Form 15A from both the 15 and 24-month visits. This question asks the mother whether a health professional ever told the mother that her child had special needs. If the answer was yes at either 15 or 24 months, you will need to enter this information in the margins of the 36-month visit, and when you get to this question at the 36-month interview, you can update the information.

For Part 6 of the Interview (Form 39C), you will also need to fill in previous information from the "Family Finances" Questionnaire from the 1, 6, 15 and 24 month interviews.

After the interview, the three face sheets should be separated from the data portion of the interview form (follow the procedures set up at your site). The data will be checked and sent to the data center after discussing any problems or concerns with the Site Coordinator and/or Principal Investigator for your site. The first face sheet is filed in the family's folder along with the Questionnaire Log Sheet. The second and third face sheets (interview scripts and instructions) should be thrown away.

A cover sheet is attached to the front of Sections 1 and 2 of the interview forms. These identify the subject, the interviewer, and the date of the interview. Be sure these are completely filled out before sending interview data to the Data

Coordinating Unit. It is wise not to fill out the date in advance of the interview in case of last-minute cancellations.

If the mother does not live with the child full time, indicate this, as requested on the cover sheet of Section 1 by darkening "Not." This code is used when the mother shares custody with the father, or when the mother is not living with the child full time for any reason.

If the mother is not the person interviewed at 36 months, use the alternative caregiver interview forms according to the procedures described in Chapter 15.5.

If a mother requests information from an earlier interview to help her answer a question in this interview, say something like, "I'm sorry. We need you to answer this question as best as you can at this time. The earlier information might change how you feel right now. It is important for us to know how you feel at this time."

G. Interview Section 1

Throughout this interview and manual, we refer to the reference child as CHILD, not BABY. If the mother has a new baby, be sure it is clear to her that we are asking about the reference child, not her new baby.

Months and dates: "Since we last talked"

Several questions request information from the mother about changes that occurred since we last talked with the mother. At the beginning of the interview, the interviewer should mention to the mother that we are updating information on changes in her family since we last talked to her on the telephone or since we last visited with her in her home. After explaining the format of the interview and the interviewer's and mother's roles (see IV.D. above), the mother should be given the exact date of the 33 month telephone contact and the 24 month lab visit. This date may be repeated as part of the introductory statement before each section where update information is requested. However, during the statement of the question, only the month of the last contact should be given. The exact date of the contact should be supplied again ONLY at the mother's request.

You may say something like:

> "The questions I will be asking you today will refer back to two different time points. Some questions will refer to things that may have happened to you or your family since we spoke with you on DATE OF 33 MONTH CALL, when CHILD was 33 months old. Other questions will refer back to when we visited with you in our playroom on DATE OF 24 MONTH VISIT, when CHILD was 24 months old. If this becomes at all confusing during the course of the interview, please do not hesitate to ask me for clarification."

In some cases, information from the 33 month call or the 24 month Lab interview will be missing. In this case, ALL questions specifying a particular month should be asked in reference either to the month of the child's 33 month birthday or to the child's 24 month birthday, whichever is required. THIS INCLUDES updating the household chart and the Work Update chart. Because the coding of mothers' responses to these questions assumes that you have prior information from the 33 month call, you must find out what the mother's situation was when the child was 33 months old, THEN ask the questions in reference to what has happened since the child was 33 months old. We suggest you obtain all of the necessary information to be able to ask these interview questions prior to the start of the interview. In these cases, modify the script described above using the child's 33 month and/or 24 month birthdate as the exact date back to which you will be referring.

In these situations, the data supplied will be comparable at each time point to the data we have on families that have not missed any contacts. Complete information on the mother's work situation will be collected in Section II, Part 6 of the Interview.

1. Part 1: Household Composition

Question 1

The purpose of question #1 (Form 15A, Page 5) is to track changes in the child's household composition and social network.

Before the interview, you will have listed in Table 1 (Page 5 and 6) the names and the mother's descriptions of the relationships of all the household members reported at the 33 month phone call. Do not enter the relationship code until after confirming the information with the mother at the 36 month visit.

Read question 1 to the mother exactly as it is written, using only the proper name of household members. (Do not confirm the relationships of household members until after you have entered the change codes.) If no members of the household have changed, (change code 1 for all individuals listed), confirm with the mother her description of each household member's relationship to both the mother and the child. If there is a relationship change, cross out the written description, add the new relationship description, and enter the appropriate new relationship codes either at the moment of the interview or shortly after. Be especially careful in situations where the mother has married since our last interview. This new marital arrangement may change the child's relationship to other household members as well. In some cases, a person recorded as "mother's partner, not child's father" may legally adopt the study child. Do NOT change the relationship code of this person to the child to "father". Keep recording this person as the "mother's partner, not child's father".

If there are no changes in the relationships, be sure to fill in the previous relationship codes as listed on the 33 month phone call form. (Please note the misprint on Page 5 of the interview forms which refers you back to the 12 month call.) If there is no 33 month phone call form on file, go back to the most recent contact at which a particular person is mentioned and get that relationship code. If a person is not listed on any of our forms, record the name, relationship to the mother and child, plus the age, sex, and relationship codes.

If an individual has moved out (change code 2), confirm with the mother the description of the household member's relationship to both mother and child at the previous phone call. Fill in the relationship codes (either now or later) from the 33 month call form, even if these have changed. If there are no 33 month call forms on file, follow similar procedures as listed in the previous paragraph.

If there is a new household member (change code 3), record all necessary information. Write in the table the person's name, the mother's description of the relationship, and complete the codes for age, sex, and relationship. If a new baby is added to the household, round the baby's age to the closest whole number. If the baby is under 6 months of age, code 00 for baby's age. If the baby is 6 months or older, code "01" (one year) for baby's age.

If someone has moved out who is not listed on a previous interview form, record the name, relationship to the mother and child, and age, sex, and relationship codes. Enter change code 2.

If the child's father or another member of the household is temporarily away from home (for example, in military service), that person should still be coded as part of the household (change code 1). If this applies to the mother's husband/partner, complete question 2 and conduct the remainder of the interview considering the partner as living in the household.

Sometimes families move into another person's home. This would constitute a change in household composition, as the new household now includes those people living in the new location. Since each family's situation is unique, use your best judgement to differentiate temporary adjustments household arrangements (maybe only a week or two during renovations) which are not entered here as changes, from permanent adjustments household arrangements (no longer paying rent at old location, eviction), which are entered here as changes.

In some cases, mothers may give open-ended descriptions of relationships which do not exactly fit one of the relationship codes. For example, a mother may report that she and her baby live with mother's stepfather. A stepfather could be considered either a "Parent" or "other adult relative" to the mother. Similarly, he could be coded as a "grandparent" , "other adult relative", or even an "unrelated adult" to the target child. In this example, you should code the stepfather as the mother's "parent" and as the child's "grandparent". These codes come closest to describing the type of relationship this person has with both the mother and target child, despite the fact that the stepfather is not a blood relative. (Please note, however, that the child's "father" code is reserved only to reflect the child's biological father). Most importantly, make sure that your site remains consistent in how this person is coded in subsequent phone calls and interviews. If you have difficulty resolving a relationship code, please contact Marsha Weinraub.

If the mother indicates, or you have learned in any way, that the child lives with the mother only part of the time, complete item 1 for the child's household with the mother. You will also ask mother about the child's other residence in Part 6, Form 39C, at the end of the interview. This form asks questions about the residences away from the mother where the child regularly sleeps, with whom, and for how long. "Living separate from the mother" means that the child regularly spends nights away from the mother, with either the mother or the child changing residences. Vacations at grandparents do not count, nor does overnight camp or staying at relatives for short amounts of time if these occur infrequently or irregularly. What we are particularly concerned with are shared residences or shared custody arrangements.

We will consider study children in shared custody arrangements to be "full-time" residents of the mother's household.

Record in Question #1, all members of the mother and child's household who are there on a full-time basis when the child is living with his or her mother. If there are other children who live with the mother on a part-time basis and their time in the household overlaps exactly with the target child,, record these children in the full-time resident chart (under Question #1). If these other children are there only part of the time that the target child spend with his/her mother, record these children in the part-time residents chart (under Questions #3 and #4). If you feel unsure about how to code a particular situation, take the information down in detail and give Marsha Weinraub or Lyz Jaeger a call.

Ascertaining information on who and when people are living in the mother's and target child's household will require extra probing. Be careful not to use directive probes. Ask the mother general questions such as, "Can you tell me more about that?", and give her the opportunity to explain the living arrangements in her own words. It is important for the interviewer to be alert to additional information which they may learn in getting answers to Part #1, Questions 3 and 4, and the new living arrangments questions in Part #6. Complicated living arrangements may not become apparent until the mother begins to answer these other questions. Make sure that you have recorded the information in both household grids properly before finishing the interview.

Try to remember who lives in the household as you continue through the interview, because it will help guide whether to ask certain questions and the interpretation of some of the responses you receive.

To deal with the conflicts between what the mother says and what we learn from the father:

Code only what the mother says, as she says it. Not all sites will ask fathers information, and not all sites will note discrepancies in the data. The question is to be coded according to how the mother answers the question posed to her.

Question 2 (Form 15A, Page 7)

If as part of the process of going through the household chart, a mother tells you her husband/partner is temporarily away from home and she tells you the reason, code the reason under Question 2. If you are not certain, find out the reason by asking, "*And where is HUSBAND/PARTNER living now?*" Code Employment if he is on a temporary job assignment away from home or if he has a job that takes him away from home from Monday through Friday or for a week or more at a time at least once a month.

Checkpoint 1: Part-time residents and Questions 3 & 4

Read question 3 as worded on the interview protocol. Follow instructions described for full-time residents in Question #1 in order to record information pertaining to part-time residents and to confirm and record the relationship status of these residents. (Please note the misprint on the interview forms for Question 4 which directs the interviewer to fill in previous relationships codes from the 12 month visit. For change code = 2, the interviewer should fill in the relationship codes from the 33 month phone call. Again, if there was no 33 phone call form, after the interview you will need to return to the most recent records we have for the relationship code we have listed for that person.)

The children listed here are those who stay in the child's household on a regular basis -- during the summer, for example, or every other weekend. This question is not intended to record information about children, such as cousins, who happen to be visiting for a week or two (even if they come every year about this time). The cousins are considered visitors, not members of the household.

For each child who comes to stay in the household part of the time (every other weekend, or for 6 weeks during the summer, for example), record their first name, relationship to the study child and relationship to the mother as she describes it to you. Also record the child's age and sex. (Assign the appropriate relationship codes grid after the interview.)

Sometimes a child who has been living in the mother's residence on a part-time basis becomes a full-time member of the household. In this case, enter a "2" for the change code on the part-time residents grid and add this child to the full-time residents grid. Although the child is not techinically new to the home, record the change code on the full-time grid as "3" - new to the home since the last contact - and record the relationship codes, age and sex for this child.

Checkpoint 2A: Status of Mother's Husband/Partner (Page 9)

From the information you collected in filling out the household chart, check off the appropriate box at Checkpoint 2, and move to the appropriate item on the interview.

Checkpoint 2B: Status of Child's Father (Page 10)

This checkpoint and questions 11 through 14 are **ASKED** at the 36 month administration.

2. Part 2: Family Health

If there was no 33 month phone call or 24 month lab visit interview, ask the mother about illnesses and injuries that have occurred since the month in which the 33 month call or 24 month visit should have been made.

One reason we may not have made a 33 month call is that the child or mother may have had a serious illness in the preceding few months. Although you should be very sympathetic and listen well, do not record data regarding health problems prior to the month of the call or visit specified in the question, unless the problems continued into the month during which the call or visit should have occurred.

Question 15 (Page 10)

Read the four choices and record mother's response. Do not try to interpret her answer for her, even if you think two runny noses are not a good reason to rate the child's health as "fair." You can add your notes about the mother's response, but you must code the answer the mother gives you.

Question 15 & 16

Amend to read: Since MONTH when we last spoke...

Question 17 (page 10)

Mother must have received a positive diagnosis of ear infection from a physician or health professional to code this as yes. Describe the medicine in her words. If she does not know the technical term for it, record what she does know (e.g., "some kind of antibiotic," "pink liquid that CHILD took for 10 days").

Record 'Y' for question 17 even if mother did not physically take CHILD to a doctor but was instead prescribed medicine over the phone.

Question 18 (Page 11)

If the mother has not seen a doctor to certify that her child's ears are clear of fluid, or if the child is still being treated, leave this item **BLANK**. Only answer "no" if the doctor has said the child's ears are NOT cleared of fluid. (Note: this is a change from the procedures followed at 15 months.) If the child has had more than one infection since the 33-month call, record the answer for the most recent infection that required medicine.

Question 20, 21, and 22 (Page 11)

For questions #20, #21 and #22 only count as visits, times that the child was actually seen by a medical professional. (This change in procedures was introduced to the 24 month procedures June 1, 1993.) For Questions 21 and 22 do not count visits to different doctors on the same day, for the same problem, as two separate visits.

By three years of age, some children begin seeing medical professionals other than their primary pediatrician for routine care. This may include dentists, opthamologists, and even chiropractors! For questions 20, 21, and 22, count child visits to these types of medical professionals ONLY if the visit occurred for some reason OTHER THAN a routine check-up. For example, only count visits to the dentist if the child saw the dentist for a cavity filling, some dental injury, other type of dental problem. Likewise, a routine eye exam would not count as a doctor's visit in these questions but visits for vision problems would be recorded. Only routine visits to primary care doctors, for check-ups and immunizations, should be counted as doctors visits in Questions 20, 21, and 22(1).

Some of our study children have already had medical problems which necessitated visits to specialists. Perhaps the most common problem of this type is recurring ear infections. When visits to a specialist occur because of a persistent illness or condition, code these visits as "follow-up" visits. If, however, the mother takes her child to a specialist (because the child is having a problem) without first seeing the child's primary doctor, you can record this visit as an initial visit for an "illness", "injury" or "other", whichever is appropriate. If the mother takes her child to a specialist for a routine check-up which is not a follow-up on a previous condition or illness and the child not currently ill, do NOT count these as "routine check-ups" in Question 22 or as doctor's visits in Questions 20 and 21.

When you ask the mother how many times the child has been to the doctor, she will often begin to tell you the reasons. You can move immediately to Question 22 and walk her through the responses. To slow her down, giving you time to record, you can simply repeat what she is saying and confirm it. If a mother never actually states herself how many times her child has been to the doctor remember to confirm the mother's answer to Question #21. Your conversation might sound like this:

I: *"How many times?"*

M: *"Well, we went in early March for shots and then he got a bad cough..."*

I: *"So he had a routine check up and immunizations in March?"* (Mark Y for response 1.)

M: *"Yes, and then he got sick."*

I: *"Was this a follow-up of an earlier problem or chronic condition?"*

M: *"No, this was the first time he'd been sick."*

I: *"So you took him to the doctor for a cough. What did the doctor say was wrong?"* (Mark Y for response 3.)

M: *"He had bronchitis."*

I: *"Was Kevin hospitalized for that?"*

M: *"No, but he was sick for a week."*

I: *"Has Kevin been to the doctor for anything else?"*

M: *"No, those are the only two times."*

I: (Record 02 under Question 21.)

Repeating and confirming the information with the mother allows you to obtain accurate information in a conversational manner.

You may record more than one reason per visit if applicable. For example, a mother may take her child for a follow-up visit for an ear infection at a time that coincides with a routine examination. A mother may also take her child to the doctor for one reason, such as a routine check, and then the "reason" for the visit changes after arrival at the doctors. If this happens, code both reasons for the visit.

Question 22 (1) Routine Check-up or Immunizations refers to well-child visits or immunizations. These may be scheduled at different times by different pediatricians or clinics. We are not trying to determine which immunizations the child has received.

Question 22 (4) asks in greater detail about injuries. You can indicate more than one response on 4b-4d (which you may need to do if the child has more than one injury since the [month of the] 21-month call). If the mother says "none" in response to Question 22 (4b), leave this question blank.

If an injury occurred at home with the father (mother not present), code #3, during child care (home, center, other's home).

Finally, remember to probe regarding a hospitalization for each visit unless it was for a routine examination. A hospitalization refers to an overnight stay, not to outpatient services performed in a hospital.

Question 23 (Page 13)

The purpose of this question is to identify children who are disabled or have serious illnesses or conditions which will affect their development, that is, their ability to accomplish such developmental tasks as learning to talk, read, walk, etc. Do not record illness or conditions that do not restrict normal activities or interfere with development, no matter how serious or "of concern" they may be. Fewer then 10% of our children will have one or more restricting conditions.

Although this question is not written as though you have information from a previous interview, you will be asking it as such. Prior to the interview, you will note the mother's answer to this question on BOTH the 15 and 24 month Standardized Interviews. If the mother did say that the child had special needs at 24 months, you will modify the question to read: "I see that at our previous interview you indicated that you had been told CHILD had (SPECIFY SPECIAL NEED). Has that diagnosis continued?". If the answer at 24 months was affirmative, but subsequent examinations show the child no longer has the condition or illness indicative of any special needs, enter "N" as the answer to Question 23. If the answer at 24 months was affirmative, but specific nature of the diagnosis has changed, enter "Y" in answer to Question 23 and record the new diagnosis. If the answer at 24 months was affirmative, and the specific nature of the diagnosis has not changed, enter "Y" and the diagnosis from the 24 month Lab Visit interview.

If the answer to Question 23 at 15 months was affirmative, but at 24 months, the child no longer had the condition or illness, rephrase the question to reflect the family's history at 15 months (illness) and at 24 months (no illness/condition). Say, "At 15 months you were told that CHILD had (special need), but at 24 months, doctors said that this was no longer the case. Since CHILD turned 24 months old, has a doctor or other medical professional told you that CHILD has special needs (that is, that CHILD has a condition or illness that restricts, or will restrict (his/her) normal activities, or that will interfere with child's development?)" Enter the mother's answer that reflects the child's diagnosis at 36 months.

Sleep Problems: Questions 24-28 (Page 13-14)

Read the entire question as written, including the information in parentheses if it is relevant to the mother's situation.

The intent of questions 24 through 27 is to assess child sleep disturbances as indicators of possible emotional or general psychological distress or lapses of parenting that may affect the developing parent-child relationships. The intent of question 28 is to assess how much of a problem the child's awakenings have been for the mother or other family members.

Videotaped records show that babies and young children, like adults, generally wake up several times a night. However, these awakenings are generally not noticed by other family members and the child returns to sleep uneventfully. What we want to count are those awakenings or sleep disturbances for which the child does NOT return to sleep uneventfully. We want to count their frequency and their duration.

The person in most families likely to awaken to a young child's sleep disturbances is the mother. Therefore, we are asking the mother whether the child has awakened her during the night. She may not be aware of whether the child has awakened anyone else in the household. Sometimes household members other than the mother have been awakened by the child. These other awakenings should also be counted.

During a home visit at 6 months, a mother reported that her baby cried out in his sleep, waking the mother, but the baby was still asleep! Another case (that we can imagine but that has not yet been reported to us) is one in which the baby may have awakened the husband or another family member, but not the mother. These circumstances are unusual, but you may want to be prepared for them, and the phrasings of the questions are designed to take this into consideration.

Read the information in parentheses in question 24. In question 26 and 28, only read the information in parentheses if there are people other than the mother and child in the household.

For Question #27, we are only concerned with how long the baby's sleep was disturbed, not how much sleep the mother or of anyone else in the household lost. Some children may only wake up for a minute or so, then go right back to sleep. The mother, on the other hand, may make herself some tea, watch TV, or read a book, sometimes for hours. Though we empathize with the mother, we are only concerned with how much time the child is up. If the mother says that the baby was not awakened, read the whole question, including the information in the parentheses and record the number of minutes until the baby went back to quiet sleep.

If a mother says her child woke up more than an hour before the child's usual time for getting up and did not return to sleep, record the amount of minutes the child was awake prior to the time when the child would usually be getting up.

Question 28 (Page 14)

This question deals with how much of a problem the child's sleep disturbance has been for the mother or other members of the household. Some people may wake up several times a night, but they have little difficulty returning to sleep and do not find the awakenings disturbing. Others, who may only be awakened once a week for a moment, may find the awakening very much of a problem. Sometimes it is other members of the household who are awakened (though the mother is not) yet this may be a serious problem to the mother. Ask how much of a problem the child's sleep has been to the mother or any other member of the household.

Question 29 (Page 14)

Select breast feeding or nursing to fit the usual terminology in your region.

Be sure to update your information from the 24 month Lab Visit Interview forms. (The interview form is a bit confusing here.) Do not ask about breastfeeding unless the mother was still breastfeeding at 24 months.

Mother's Health: Questions 31-34 (Page 14-15)

While Question 31 refers back to how the mother feels her health as been since the month of the 33-month call, the caller did not record and code the answers so that they are equivalent to questions 32-34. The mother may have volunteered this information, thus the interviewer may know more about the mother's health at 33-months. However, there is no record of this information in the computer. Therefore, question 32 refers back to information supplied by the mother at the 24 month lab visit.

Questions 32-34 should be read with the month of the 24 month visit or the month in which the 24 month visit would have occurred. You may "set-up" these questions by saying something like: These next questions refer back to May 10 (using exact date), when we last visited you (or, if no visit, when CHILD was 24 months old.) Remember to amend all of these questions to read, "Since MONTH, when we last spoke/visited with you...".

Question 31

Read the four choices to the mother and get her description of her overall health. Do not try to interpret her answer, even if you think differently than she does.

If mother begins talking about her health problems, move through Questions 32, 33, and 34, getting specific responses as quickly as you can without being rude. Do give the troubled mother a chance to complain or explain, but do not encourage long descriptions of health problems. If a mom is clearly distressed often, a sympathetic, "I'm sorry to hear that," followed immediately by the next question, will get the conversation back on track.

Be sure to record health problems described by the mother as these may be important in her ability to (a) work and (b) provide care for her child. Also, it will help build rapport with the mother.

Question 32

Not all illnesses recorded during the 24-month visit should be subject to follow-up at 36-months. Ask only about problems that you might reasonably expect to have continued. For example, do not ask about colds or flues, but do ask about backaches or diabetes. Not only will this help build your relationship with the mother, but it will provide an indication of the extent of the mother's health problems and how they may affect her ability to work. When a mother has 2 or more chronic health problems, you should re-phrase the question to include a description of all problems and ask, "Are these still a problem?" If mom says yes to at least one, code response as yes.

Question 33 and 34

If mother indicates any new health problem (since [the month of] the 24 month Lab Visit), get her description of the problem and record what she says. Much of this specific information is useful primarily to your site. It helps you become acquainted with the family and to keep track of events that may influence participation in the study.

If the existence of a health problem does not get mentioned until Question 34, you may probe further by asking, "*Would you consider _____ to be a health problem you have developed since*

MONTH?". If the answer is yes, then record this information and mark Yes under Question 33.

Mothers' responses to Question 34 are difficult to code when they say something like, "Yes, I was at the doctor for my routine check-up." The mother is saying yes but her response indicates she may not have understood the intent of the question which concerns seeing the doctor for any illnesses or conditions. If the mother answers this question affirmatively and then tells you that the reason for the visit was a routine check-up or exam, you must probe her answer further. Ask the mother, *"Were any of these visits for an illness or condition?"*. *If the mother says "yes", ask her to specify the other reasons and code "Y" . If the mother says "No", code "N".*

Pregnancy is counted as an "illness or condition".

Question 35 (Page 15)

Ask this question only about a live-in husband/partner.

As with the earlier general health questions, read all the responses and record the mother's choice. Do not interpret her response.

Question 36 through 40 (Page 16)

The purpose of these questions is to identify any important events impinging on the mother or the family. It also gives the mother a chance to talk about important events that are not covered elsewhere in the interview.

Remember to ask "Anything else?" after the mother reports problems of any kind. In reporting one problem, the mother may *forget to mention other serious problems. As with all open-ended questions, you should keep probing until the mother has no more information to give you that is relevant to the question.*

When a mother reports any of these events, interviewers should not make any comment in response unless the mother herself shows distress or sadness. For example, death of a very ill or very unloved relative could be a positive event when viewed through the mother's eyes. Only when the mother expresses clear sadness or grief should interviewers express sympathy. The interviewer should limit any statement to a sentence and then move on (with a reasonable pause as necessary) to the next item.

Interviewers are also cautioned against responding positively to what appear to be positive events reported by the mothers. We do not want to appear to be encouraging mothers to be reporting positive events to us. Rather, all events, whether positive, neutral, or negative, should be responded to in a neutral manner by the interviewer unless the mother expresses distress.

The answer codes in questions 36, 37, 38, and 39 pertain to the relationship between the mother and the person in question. If the mother responds that the person was one of her children, code this as "other close relative" (#4).

Question 37

Do not read the information in parentheses, but do mark a "yes" answer here if the mother mentions alcoholism or addictions. If you ask this question and the mother answers "No" *despite the fact she told you earlier that a relative or close friend has alcoholism or addiction problems, you may ask about this situation using confirmation. You may re-enter the data as necessary.*

Question 40

This question is only concerned with the mother's moves. A move is a change in location of household. A new apartment even at the same address, is a "move."

H. Interview Section 2

1. Part 3: Mother's Employment and School

NOTE: Throughout this section, a mother is considered now working for pay if she is currently going to work at a paid job. This job may take place in her own home. Mothers who are on leave or doing volunteer work or working in exchange for services are not considered, for our purposes, to be now working for pay. (Please note that some mothers may both be paid by and also volunteering for the same organization. If this is the case, only ask the employment questions such as number of hours worked or times of day worked, in reference to the time for which she is actually paid.) Record job information even if the mother works only a few hours a week.

Remember, mothers who are on maternity leave are considered, for purposes of this interview, to be "not working for pay". Sometimes a mother who is on leave from her job performs activities related to her job for which she receives no *additional pay above and beyond the compensation during her leave. According to our definition, this mother, too, is not working for pay.*

Question 1, 2, and 3 *(Page 2)*

The Work Update Chart allows you to record a lot of information in a small amount of space. Before going on the visit, you should fill out the Work Update Section for Primary and Secondary Jobs if the mother was working for pay at the 33 month contact (or the child's 33 month birthdate). You should include her position title and employer. A change code must be entered for each job recorded. For mothers who were not working for pay at the previous contact, these sections are left blank prior to the visit.

When updating employment information, it is necessary to distinguish mothers who are working more than one job versus those mothers who are consultants or independent contractors with several different employers or clients. For example, some nurses work for several different registries or a speech therapist may have several different clients. Frequently these mothers describe themselves as being "on-call" to several different employers. This type of job should be recorded as one job. Distinguish this situation from one in which the mother performs the same services on a regular, permanent basis for two or more employers (e.g. the mother is on staff as a waitress at two different restaurants). In the latter case, the mother should be recorded as having two (or more) separate jobs.

In this type of situation, we also want to be careful what we consider a change in job status. Mothers who regularly work the same type of job (i.e. speech therapist) for several different clients or registries/agencies should NOT be coded as having a change in job simply because they add or drop one of their "employers". If, however, the mother becomes a regular part-time of full-time employee for one of her previous or new "employers", this should be recorded as a new job. For example, a mother who works through a "temp" agency as a clerical worker should not be considered as having a new job simply because she adds a new "temp" agency to her list or because her agency sent her to a new client since the last interview. If, however, the mother becomes a permanent employee of some company as the result of one of her temp jobs, this should be recorded as a job change. If you encounter a difficult coding situation, get as much detail as possible and send your case to Marsha Weinraub or Lyz Jaeger.

Mothers who work essentially as independent contractors or consultants or are self-employed, frequently have irregular working hours. Remember to average the number of hours worked per week over the last month to get an estimate of hours per week.

Question 1

For mothers who were not working for pay at the 33 month contact (or child's 33 month birthdate), begin with Question 1. If the mother has begun a new job; that is, she is currently at a job which she began after the 33 month phone call, fill in this *information in the Work Update under Primary and Secondary Job Info. using "NEW JOB INSTRUCTIONS" below. [Do not record any job information for jobs she may have both started and ended between the 33 month call and 36 month interview.] You should record information for no more than two new jobs. If the mother works for pay at two jobs, you need to determine which job is primary and which job is secondary. The primary job is the one the mother works at for the most hours. If the mother has two jobs and works the same number of hours at each, the primary job is the one with the higher salary.*

On the basis of the 33 month call, you will not know if a mother was not employed at all or if she was on leave at 33 months. You will only know she "was not working for pay". If you know the mother was on official leave at our last contact, sensitively remind her that our definition of not working for pay may be a bit different from hers and that some questions may seem a bit awkward. Be especially sensitive since you need to ask the mother all of the information about her "new" job even though she may just simply be returning to a job for which she has already given us information at a previous contact.

NEW JOB INSTRUCTIONS. To complete the work update for a new job(s), you should use the following prompts. "What is your position title?" MAKE SURE THAT YOU RECORD THE POSITION TITLE ACCURATELY AND CLEARLY. Contrary to previous interviews, regardless of how clear the mother's position is to you, ask "What are your most important activities or duties?" and record what the mother says. Then ask, "What kind of (business/organization) is that?" and record the type of product manufactured, the primary activity of the organization, or the nature of the business.

Use the occupation coding definitions to choose an occupation category. Get as much information from the mother as you need to accurately code her occupation. For example, if you have learned that the mother works as a nurse, you need to find out if she is an RN (coded under Professional) or an LPN (coded under Technicians). Self-employed mothers frequently have an occupation that could fit under two coding categories. For example, they do administrative work to run their business (e.g. taking care of the books) and also participate in the activity of that business (e.g. clean houses if they own a cleaning contracting business). If the mother is both an administrator in her own business and also participates in the activity of the business, code the occupational category according to her "hands-on" activity. If the mother is a full-time administrator, code her occupation as an administrator. If you have questions about the proper code, talk to your site coordinator or principal investigator. The occupational coding categories can be found in Chapter 7, Appendix A.

Then ask, "When did you start working at this job?" To get income information, ask, "From either annual or monthly categories choose the one that best (represents/represented) how *much you (earn/earned)."* Add, *"Is this before or after taxes?"* and hours *"How many hours a week (are/were) you working for pay?"*

Question 2

If a mother was working at our previous contact, begin with Question 2 and update the information on jobs you listed under "Primary and Secondary Job Information." Update for the primary job first and then ask about the secondary job.

--- For any job in which there was no change (code=1), update the income information by asking, *"From either the annual or monthly categories, choose the one that best (represents/represented) how much you (earn/earned)."* Add, *"Is this before or after taxes?"* and *"How many hours a week (are/were) you working for pay?"*

--- If the mother has stopped working for pay at this job permanently, fill in Change Code 3, and ask, *"When did you stop this job?"*. Also ask the mother, *"From either the annual or monthly categories, choose the one that best represents how much you earned?"*, and record her income. PLEASE NOTE THAT THIS IS A CHANGE FROM THE 24 MONTH INTERVIEW PROCEDURES.

--- If a mother says that she is temporarily away from her job on some type of leave other than being on vacation (e.g. before or after the birth of another baby, long-term disability, leave of absence, a sabbatical, etc.), confirm with the mother that she is currently not working any number of hours for pay either inside or outside of the home. If the mother is working any hours for pay (that is, above and beyond any leave salary benefits), we consider her still employed. For purposes of our study, the most important characteristic defining a mother as being on leave, is that she and her employer have agreed upon a specific day on which she will return to work. If the mother's leave time arrangements are more informal, enter change code 3 (for job stopped) and follow the appropriate skip patterns. Remember to sensitively remind the mother that our definition of not working may be a bit different from hers and that some questions may seem a bit awkward (e.g. Why did you stop working at this job?).

If a mother fits our definition for being on leave, fill in change code 6 and ask, "When did you go on leave from your job?". Record this date under "Ending Date". Throughout the rest of employment update section, this mother is considered not working.

--- If a mother is on a regular, paid or unpaid vacation of 1 month or less, we treat her as still currently employed. In the Maternal Employment Update, we enter change code 1 and record her usual number of hour employed/week since our last contact. We also record her salary as she gives it to us. For the rest of the employment questions, she is considered employed. NOTE: We only consider the mother as being on official vacation time if she and her employer have an agreed upon date for her return. If she is just more informally taking time off from her job, count the mother as having stopped her employment (change code 3).

If a mother is on a paid or unpaid vacation for longer than 1 month, enter a change code 1, record "00" for number of hour employed per week, and record her income. The rest of the questions pertaining to her employment can be asked in reference to when she is not on vacation.

If there is question about whether she will return to her job after an extended vacation, treat the mother as having ended her job (change code 3). Follow the skip pattern appropriate to her having ended her job but be sensitive to the fact that she might still consider herself an employed mother.

--- If a mother has experienced a change in her job title or position, but her employer has not changed, fill in change code 2. Update the mother's new information by asking *"What is your position title?"*. RECORD THE NEW JOB TITLE ACCURATELY AND CLEARLY ON THE INTERVIEW FORM. Even if the job title is clear to you, ask *"What are your most important activities or duties?"* and record what the mother says. Now choose a new occupation coding category from Chapter 7, Appendix A. Get as much information from the mother as you need to accurately code her new occupation rating. For example, if the mother works as a nurse, you need to find out if she is an RN (Coded under Professional) or an LPN (coded under Technicians). Self-employed mothers frequently have an occupation that could fit under two coding categories. For example, they do administrative work to run their business (e.g. taking care of the books) and also participate in the activity of that business (e.g. clean houses if they own a cleaning contracting business). If the mother is both an administrator in her own business and also participates in the activity of the business, code the occupational category according to her "hands-on" activity. If the mother is a full-time administrator, code her occupation as an administrator. If you have questions about the proper code, ask your SC or PI.

Next, ask the mother, *"When did you start this job?"* Record the date she started her new position. Finally, update her income by asking, *"From either the annual or monthly categories, choose the one that best (represents/represented) how much you (earn/earned."* *Add, "Is this before or after taxes?" and "How many hours a week (are/were) you working for pay?"*

If a mother gives both the before and after tax salaries, enter the "after" tax salary. If the mother reports both her yearly and monthly income, and they conflict, ask her to choose one. If she can't choose, record both and send a data edit form to the DCC explaining the situation.

Be sure to mark an appropriate code for Job 2. The NA code under Job 2 indicates that there is only one job being recorded.

Question 3 (Page 2-5)

If a mother has begun a new job since the previous contact, record this information on the Work Update under the "New Job Information" following the instructions above called "NEW JOB INSTRUCTIONS" to complete the Work Update grid. Do not get information on jobs that the mother both started and ended between the 33 month call (or, if there was no 33 month call, from the date the child was 33 months old) and the 36 month interview.

In unusual cases, a mother may be currently working at three (or more) jobs, but there is only space to enter information from two jobs. Since we care most about the total number of hours that the mother works and her income, we will be combining information from all secondary jobs in the Secondary Job information. Report the occupation code for the job with the higher occupation code. Enter the total salary and total hours per week from all the secondary jobs. For all subsequent questions about the mother's employment, the mother may respond for all jobs combined.

If a mother works every other week, or some non-weekly schedule, average the number of hours worked per week over a one month period to get an estimate of "hours per week". Some mothers, such as those in the Reserves, may work on a monthly and a yearly schedule such as one weekend a month and two full weeks per year. In estimating number of hours per week, do NOT count the yearly hours UNLESS the mother worked those hours in the previous month.

Question 4 (Page 6)

Interviewers may want to "re-set" the stage before asking question 4 on page 6 of the interview.

Count only hours at home for which she is paid, and, if she is a salaried professional, hours that are directly related to her paid employment. If the number of hours varies, ask for the "most typical situation" in the mother's opinion. The answer should be reported and recorded in terms of hours per week.

Question 5 (Page 6)

If mother's work falls within one of the time periods listed in Question 5, record that period even if she does not work the whole time. For example, if she works from 1 to 5 p.m., record (1) Daytime. If she regularly works hours that overlap the intervals listed, record both times. For example, if she works a 12-hour nursing shift from 11 a.m. to 11 p.m., record both (1) Daytime and (2) Evenings.

Similarly, if a mother works days and evenings on a regular basis because of having two jobs, record both. If a mother's hours change from day to day on a regular basis (for example, she works 1-5 p.m. on Mondays, Wednesdays and Fridays, and 1-9 p.m. on Tuesdays and Thursdays) record both (1) Daytime and (2) Evenings. Category (4) Times Vary should be used only when the mother's hours are different from week to week: mother works days one week and evenings the next.

As always, read the question as written. Do NOT read the response options given.

Questions 4, 5, 6 and 7 refer to all the mother's jobs combined.

Question 6 (Page 6)

The intent of this question is to identify mothers who have to be away from home for at least 24 hours. Mothers who regularly work a night shift are not considered to be away from home overnight in connection with their job.

Question 8

Hand Card 8 to mother and ask her to choose the most important reason. Record Other only if none of the choices fits her situation. (Note: Card 8 was modified to list reason 9 as New baby, reason 10 as other.)

Mother's health includes her mental health. For example, if mother says she experienced emotional tension or exhaustion, code 4, mother's health. Note that you do not have to ask the mother if she considers "emotional tension" to be a "mother's health" reason; the study is defining it that way.

Child's health includes behavioral reactions of the child in child care, such as the mother's belief that the child was having stomach distress, sleep problems, or eating problems.

Childcare problems are the "external" problems of finding appropriate and affordable child care. They may include lack of available care, losing a care provider, care that is too expensive or inconvenient, care that is unreliable or of poor quality, distrust of sitters, and the like.

Work-family demands in conflict includes employer inflexibility about the mother's need to take time off for family or personal reasons, or the mother's own feelings of not being able to cope with competing demands.

A Mother's initial response to Question 8 may not be codeable. She may say she just changed her mind, or she thought she would be able to handle working and caring for her child but found out she couldn't. For responses such as these, ask her to

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choose which of the listed reasons was the most important in her decision.

Question 10 (Page 7)

"Going to school" is defined as enrolled in an educational program that normally leads to a degree, certificate, diploma, or the attainment of job-related skills. Correspondence courses may count here. Taking an evening course just for the fun of it does not count as going to school, nor does taking a parenting class offered by the local hospital. On the other hand, if the mother is taking an evening course on computers because she is planning to start a word processing business at home, then it should be recorded. Similarly, if the mother is enrolled in something like 6 credit hours at the local community college she should be counted as attending school even if she is not officially in a degree program. All credit courses should be counted as "being in school" even if the mother is not officially enrolled in a degree granting program.

Knowing what kind of school the mother attends is important for later questions. It also helps build and maintain rapport with the mother. Although this information will not be entered into the database, it is valuable for your future conversations with the mother.

If the mother is on a school vacation, and this break is to last one week or less, code the mother as going to school right now. To record number of hours and times of day (Questions 13 and 14), refer to situation immediately prior to the break. If the mother is on break for longer than one week, code the mother as "not in school". Question 15 will be coded with the date of the mother's last day of school work, and the reasons for stopping school will be "school on break". Usually mothers do not offer the information that they are currently on break if it lasts only a week or less. DO NOT probe to find out if mothers (or partners) are on break if the mother says that she is not in school "right now". Record the information as she gives it.

Question 13 (Page 8)

The intent of this question is to find out how much time the mother spends doing school work -- time in class plus time spent on school-related work. As a general rule, use the following coding guidelines for counting hours in school. For high school or vocational school where people enter a building and attend classes for a portion of each day, count the number of actual school hours (e.g., 8:30 to 3:30 for five days a week would count as 35 hours). For community college, college, or graduate school, count the number of credit hours in which people are enrolled multiplied by 3 to get an index of involvement with school (e.g., a student enrolled in 12 hours -- which is considered a full-time load -- would be recorded as going to school for 36 hours; a student enrolled for one course of 3 hours credit would be recorded as going to school for 9 hours). Although different types of schools vary somewhat in their time requirements, these calculations will provide a general index of time spent.

Question 14 (Page 8)

If mother's school hours fall within one of the time periods listed in Question 13, record that period even if she does not attend to school the whole time. For example, if she attends school from 1 to 5 p.m., record both (1) Daytime. If she regularly attends school during hours that overlap the intervals listed, record both times. For example, if she is in school from noon to 7 p.m., record both (1) Daytime and (2) Evening. If a mother is in school during both daytime and evening hours regularly during the same week but on different days, record both (1) Daytime and (2) Evening. Use (4) Times vary only for situations where the mother goes to school days one week (for one month) and evenings another.

Question 16 (Page 8)

Hand Card 9 to mother and ask her to choose the most important reason. Record Other only if none of the choices fit her situation. (Note: card 9 has been modified to list reason 9 as school on break, reason 10 as new baby, and reason 11 as other.)

2. Part 4: Husband-Partner Employment and School

We are limiting the information we gather on husband/partner employment and school to information which we consider most important to our research questions: whether he is employed or in school, how much he earns, and how many hours he spends at work or in school.

In this section, we are collecting information about the husband's/ partner's current job situation, as of the day of the interview. We update this information every 3 months during the course of the study. Throughout this section, partners are considered now working for pay if he is currently going to work at a paid job. This job may take place in his own home.

Question 21 and 22

For the husband/partner's school information, please follow the definition of school enrollment and instructions for coding school break information as described for mothers (Part 3, Question 10).

A tricky coding situation arose at 24 months in which a father was being paid by the military to attend medical school. In this case, his job is going to school! To reflect this type of situation, you should record "Yes" to Question 17. In question 18, record his income -- that which the father is being paid to attend school plus any additional income he may receive for other paid work. In Question 20, record "00" unless he is also doing some additional work for his income besides attending school. Record "Yes" for Question 21. In Question 22, record the number of hours he is in school.

3. Part 5: Feelings and Attitudes about Employment

Questions 23 and 24 (Page 10)

Give the mother card (3) while you read the question. Choose the wording (working, not being employed, or going to school) that fits the mother's situation. If the mother works any number of hours, read the question using the "working" option. If the mother is on leave, ask how satisfied she is with the decision to be "on leave" right now.

Question 25

Give card (4) to mother and ask her to choose the one that reflects how she feels right now. Do not fill in more than one response. If the mother gives you more than one, ask her which one would be "most ideal" for her right now.

4. Part 6: Updating Our Files

Additional questions have been added to the standardized Interview. These questions were not printed on the forms that are being used to collect the 36 month data. Thus, you will use an additional form to collect the answers to these questions (Form 39C).

The last question in the Interview Section 2 (page 10) is "If you could have your ideal situation, what would it be right now? Proceed from this question directly to the additional questions on Form 39C.

Questions 1 through 17: Health Questions

The purpose of these questions is to establish the kinds of treatment available to the family, the means of payment, and the illnesses and severity of these illnesses that the child has experienced. These health questions were prepared for us by Mary Overpeck of the Cognitive Laboratory of NICHD, and they are taken from the National Child Health Survey.

This section has instructions for administration which are different from those in other sections of this interview, as you will see. This is because we want to have our interviewers ask these questions in as similar a way as these questions were asked in the National Child Health Survey so that our data can be compared to those data. If you have problems or questions with these procedures for administering these questions, please let us know, and we will try to help you as best we can.

Question 1

Ask question 1 to determine whether or not there is one particular place this child usually receives routine health care. If the response is not "yes" or "no" but there is indication of more than one doctor or place, reask the question emphasizing "particular" and "usually." If the response is still not yes or no, mark the "no" box. If the child is bedridden but has a particular doctor come to the home to give medical care or advise consider this a "yes" response. Do not lead the respondent by referring to a "family" or "regular" doctor.

Routine Care - is defined as a visit for the purpose of determining the general state of the sample child's health. This includes checkups for specific purposes, such as periodic (yearly) checkups, and for other similar purposes.

Do not include a visit for a checkup or examination for a specific condition, such as a checkup for high blood pressure, a heart condition, and so forth.

Question 2

Ask question 2 to determine the kind of place. If the response is "Hospital," "Health Center" or "Clinic," ask the appropriate probe question to determine if this was the outpatient clinic, emergency room, company clinic, etc. Mark the box which indicates the kind of place, not the name of the place.

Some definitions to use in this question are:

Rural Health Center: A public or private ambulatory facility generally sponsored by a unit of local government which provides medical care only to residents in a rural area.

Home: Any place the sample child was staying at the time of the doctor's visit. It may be his/her own home, the home of a friend, a hotel room, etc. Be sure the respondent does not mean that the visit took place at the office in the doctor's home.

Doctor's Office: The office of a doctor in private practice. This may be an office in the doctor's home, an individual office in an office building, or a suite of offices occupied by several doctors. This category also includes "doctor's clinic," meaning the office of a group of doctors.

Company or School Clinic: A company or plant doctor's office or clinic which is operated solely for the employees of that company or industry; or a clinic at a school for the use of students.

Hospital Outpatient Clinic: A unit of a hospital where persons may go for medical care without being admitted as an inpatient.

Migrant Clinic: Clinic set up to serve migrant farm workers.

Hospital Emergency Room: A unit of a hospital where persons may receive medical care, usually of an urgent nature, without or before being admitted as an inpatient.

Community, Neighborhood, or Family Health Center: A public or private ambulatory facility generally sponsored by a unit of local government (sometimes receiving Federal funding).

They provide medical care only to residents of a particular area.

HMO/Prepaid Group: This is a type of medical care facility that provides care only to members of a Health Maintenance Organization ("prepaid group") health plan.

Question 3 through 6

Handle questions 3, 4, 5, and 6 in the same manner as questions 1 and 2.

Question 4

If "same place" is marked in question 4, mark the corresponding box in question 5 without asking the question.

Question 6a

Ask question 6a to determine if the sample child usually sees a particular medical person at the place specified in question 5. If he/she usually sees or is seen by different medical persons or various visits, mark "no", and go to question 6b.

Question 6b

Question 6b includes anyone who knows enough about the child's health condition to give advice.

Question 7

Ask this question only if mother reports no particular place to go when child is sick. Hand Card 16 to mother and ask question 7. If the person does not give a number from the card but gives a response that is exactly the same as one listed, circle the appropriate number. If the response is not exactly the same as one of the listed categories, ask for a number. If the answer still doesn't fit, circle "6" and enter the response verbatim. If you are given more than one number reask the question reemphasizing "MAIN."

Question 8 through 14

Questions 8 through 14 ask about surgery for ear-tube placement. These questions provide somewhat different information from that we collect from the physicians. These questions are especially important for those cases when we cannot collect data from the physicians.

Question 15

Question 15 (a,b,c,d) is a list of child health conditions and probes about their duration that must be asked to all mothers. Depending upon the duration of the condition, mothers will then be asked a set of follow-up questions for EACH condition. These questions are included on the Health Condition Follow-up (Form 39C-a). YOU WILL NEED TO CARRY SEVERAL EXTRA COPIES OF FORM 39C-a WITH YOU AT ALL TIMES, so that you have space to probe about each condition separately. You will complete all relevant parts of question 15 (a,b,c,d) BEFORE going on to complete Form 39C-a, Health Condition Follow-up.

Question 15a

For each condition you will start by asking question 15a which asks if the child has EVER had the condition. Ask question 15a for all the listed conditions before asking question 15b (occurrence of condition in the last 12 months). Thus, you will read down the list of conditions, marking her answers in the first column of the page. Repeat, "Did CHILD ever have (CONDITION)?" before reading the name of the condition as often as necessary.

For conditions with "Specify ____" spaces, such as "any other persistent bowel trouble", probe and write in the exact condition before continuing with question 15a for the next condition on the list.

Several items have multiple conditions. If the specific condition is reported, CIRCLE it; otherwise, probe to determine it and then circle it. For example, when asked about "Frequent or Repeated Diarrhea or colitis" the respondent says, "Yes, he had frequent diarrhea." Circle "Frequent" and "Diarrhea" for future reference. Use the circled name in ALL follow-up questions about this condition.

When asking about deafness or blindness in Group K or L, first ask "Deafness or trouble hearing with one or both ears? If that response is "yes", ask "Is it one or both ears" and mark the appropriate "yes" in the question 15a answer space. If the initial response is "no", mark the "No/DK" box.

If "Yes" response is given to "Any other condition that lasted three months or more?" in Group P, mark the "yes" box, then probe for the conditions and enter them on the lines provided. Do not record more than three conditions.

Colitis is pronounced CO LIE TIS, with accent on the second syllable. Feel free to look up any other terms you are not sure how to pronounce.

Questions 15 b,c,d

The purpose of these questions is to probe more specifically about the duration of any health conditions the mother indicated that the child ever had and to identify the conditions for which you need to complete the Health Conditions Follow-up (Form 39C-a). Ask questions 15 b,c,d, as appropriate, for each condition the mother responded "yes" to in question 15a. Insert the listed or circled condition when asking question 15b (and 15c) as the name of the condition. Please note that you will not ask 15c or record information for 15d for every condition the mother says "yes" to in 15b. Follow the interview grid. If the box is blank for a particular condition, you will not be asking the question identified at the top of the column.

After marking the mother's response in 15b, follow the instructions next to the answer marked. If the mother says "no or don't know" to question 15b, then ask question 15b for the next condition with a "yes" in question 15a.

If the mother says "yes" to question 15b, then you will do one of two things. Either you will enter the name of the condition on top of Form 39C-a or you will go on to ask question 15c about that condition. For the four conditions about which you need to ask question 15c (food or digestive allergy, persistent bowel trouble, deafness or trouble hearing, and eczema or other kind of skin allergy), mark the mother's answer and follow the instructions next to the answer marked in question 15c.

After you have entered the name of the condition on Form 39C-a, Health Condition Follow-up, following question 15b, 15c or 15d, finish asking questions 15 (b,c,d) about other conditions BEFORE asking the questions listed on the Health Condition Follow-Up. NOTE: Enter only one condition per Health Condition Follow-up Page. Use as many forms as necessary.

Do NOT ask question 15d of the mother. When instructed to go to 15d (deafness or trouble hearing), mark "yes" or "no" to indicate if the condition is obviously permanent.

Health Condition Follow-up (Form 39C-a)

After completing questions 15a,b,c,d, you will ask more questions for each condition you entered onto the Health Condition Follow-Up (Form 39C-a). The questions ascertain the extent to which the child's life has been affected by having the conditions identified in question 15. Before asking the specific questions for the condition listed on top of the page, make sure to mark the letter from question 15a corresponding to the condition.

Although Question 2 may seem strange to ask concerning a child at this age, we have been assured that for serious illnesses, children do stay in bed, and this question is important for determining severity of a condition, especially in those cases where medical access is questionable.

For Question 4, telephone calls to the doctor/nurse practitioner/other medical personnel can count here as well as in-person visits. For question 5, include any medication other than vitamins, including non-oral medication.

If the mother cannot recall the information necessary to answer any of these questions, you may repeat the question or you may say, "Give me your best estimate." IF she insists she cannot mark "DK" for "don't know".

Form 39C Question 16: Health insurance

Because whether or not a family has insurance may affect reports of their usage of medical care, we are interested in knowing here whether the family or the child specifically receives any help with medical bills.

These systems vary across states and communities. Interviewers will need to tailor the examples to fit their sites. In place of Blue Cross/Blue Shield, you should list the large private insurance company providing coverage common to your area. In place of "Health Pass", you may include the name of a program in your area available to families of AFDC or Medicaid or public assistance of any sort. We anticipate that families at all of the sites will be familiar with the term, HMO. If this question poses a problem for your site, please call Lyz Jaeger or Marsha Weinraub.

Question 18 through 23: The child's living situation: Spending nights at someone other than the mother's house.

These questions are designed to find out about other households the child may spend time in separate from the mother.

We count the arrangements as regular even if they are not planned and even if they do not occur on the same night of each week or month. What is important is that they occur at least 2 nights per month with the same person/in the same household, over a long enough period of time that the mother sees them as regular. If the mother tells you that this event has just occurred this month, you can ask the mother if she expects this arrangement to be regular, that is, to occur every month for at least 2 nights per month. If she does, count it here. Do not count as regular situation in which child stays with different people or in different households each month.

Included here are formal arrangements planned in advance as well as more informal arrangements that are generally not planned in advance. Residences of the more informal type may occur, for example, when the child stays weekends at least once a month at his grandmother's house. This may occur because the mother works on weekends once in a while or because the child likes to be with his grandma or his cousins. Sometimes a child may stay at his aunt's house for a day or so during the week. This may be because the child stays at his aunt's for day care during the day, and he stays at her house in the evening and night as well, perhaps because he falls asleep on the couch or because his mother is too tired to take him home. Sometimes a child may stay one or more days a week with her biological father who is not living with the child's mother. For these informal arrangements, there are no formal agreements that the child will stay at the other person's house; it just "happens".

Though it would be unusual in the life of a three-year-old, one could imagine that if the child regularly went on an overnight fishing trip with her dad one weekend every month, this would count here. Count here any planned regular overnights with caregivers away from the child's home, whether the caregiver is paid for this service or not. Also count here any arrangements which are viewed by the family as alternative "homes" for the child to which the child goes on a predictable, regular basis planned in advance.

In some cases, the mother may respond that she is the one who travels to a different household, living away from the child on a regular basis, leaving the child in the care of someone else for a period of time. The most common example of this uncommon situation would be in a case of joint custody, when the mother leaves home while the child's biological father moves into the house. COUNT this custody situation as a case where the child is in another household. The reasoning here is that, although the HOUSE is the same, the household is changed, it being under the care of another person. Do NOT count however, cases when the mother leaves the home on a regular basis and the child is cared for by another member of the household who lives there while the mother lives there. Also DO NOT count if the child is cared for by someone else (say, a babysitter) who comes to stay with the child during the time the mother is away; this kind of arrangement should be picked up with the information regarding child care arrangements.

If the mother responds with the relationship the person has to the child, it is ok to ask "Can you tell me the names of "CHILD's FATHER/AUNT etc.?" Likewise, if the mother responds with the proper name of this person, it is OK to ask "What is NAME's relationship to CHILD?".

If there is more than one arrangement, enter information from the three most frequent and regular arrangements in question 20 and 21.

For question 22, we are interested in how old the child was when he/she first began spending nights away from the mother. The age may or may not refer to when the child began spending time in the current arrangement. For example, the child may have spent a lot of time at grandmom's in the child's first two years, but grandmom may have moved away, and the child now spends time at Aunt Suzie's. Enter the child's age in months when the child first began spending the night away from the mother even if the specifics of the arrangement (place, frequency, people responsible for the child) have changed. We recognize that over the child's life, changes will occur in many of these arrangements, and being more specific may not be reasonable at this time. The data we collect here will give us a ball park figure of the earliest age at which these types of arrangements might have begun.

Question 23 refers to legally binding arrangements. We anticipate that these will generally refer to legal, custodial arrangements associated with separation or divorce.

After question 23, be sure to probe to see if there are any other additional households that the child regularly spends overnights, as there may be some arrangements that the mother forgot to tell you about initially. If so, enter this information into the previous questions. Continue probing here until the mother responds that there are no additional households of this kind.

Checkpoint 3: Educational and Employment status of live-in husband/partner (Questions 25 through 28)

We are changing the procedures here in two small but important ways from previous pilots and interview administrations.

The first change is that Interviewers MUST ask the questions "What are his most important activities or duties?" and "What kind of (business/organization) is that?". We are making the same requirement in the section on the mother's employment. This is because it is hard to be sure of the person's job unless we also know the person's main duties. Please write clearly here and in the section on the mother's employment, as it is anticipated that we may have to xerox these forms and send them elsewhere for coding. Be as complete as you can without spending too much time here. If you have questions about the appropriate level of data detail to collect, call Lyz Jaeger or Marsha Weinraub.

A second change is that mothers are free and even encouraged to ask the father for help on these questions! We realize that not all mothers will know the husband's position title and his activities or business, and we need to have as accurate information as possible. If the mother says that she is not sure of this information, ask if you can call her the next day after she has had a chance to ask her husband/partner about his position title, activities and business/organization, and you may enter this data to the interview forms after this call. Again, contact the Temple site if these procedures seem to be too time-consuming or intensive.

Question 27

Get as much information from the mother in question 26 as you need to accurately code the husband/partner's occupation rating. For example, if the father works as a nurse, you need to find out if he is an RN (Coded under Professional) or an LPN (coded under Technicians). Self-employed fathers frequently have an occupation that could fit under two coding categories. For example, does he do administrative work to run the business (e.g. taking care of the books) and also participate in the activity of that business (e.g. clean houses if he owns a cleaning contracting business). If the father is both an administrator in his own business and also participates in the activity of the business, code the occupational category according to his "hands-on" activity. If the father is a full-time administrator, code his occupation as an administrator. If you have questions about the proper code, ask your SC or PI.

Checkpoint 4: MY FINANCES QUESTIONNAIRE (Questions 29 through 32)

We have been concerned that in previous assessment periods, mothers answered the questions on the MY FINANCES questionnaire with annual information rather than monthly information. For this reason, at 36 months, we check the information with the mothers that was collected at earlier assessment periods. Prior to the interview, you will need to fill in the blanks (Income letter code) in question 29b on page 11 of this section of the interview. If the mother did not report income on the My Finances form during previous assessment periods, skip this item.

Questions 30 through 32: New Income

Until this assessment, we have been careful not to ask too may questions about income, because we were worried about asking such a confidential question. However, we have learned that these questions are not as sensitive as we had thought, and that mothers are very open about sharing this information even in a verbal situation when directly asked. Because this information is so important, we have added questions 30 through 32 which directly asks mothers to state how much income from all sources, the people in her immediate family received in 1993. Card 17 will remind the mother of the many sources of income that need to be included in this estimate. We want the pre-tax figures here.

By immediate family, we mean the mother, her children who live with her, and her husband/partner, if he lives with her. The question asks that the mother include income from her husband or partner only if the husband or partner lives with the mother. This is because if the husband/partner does not live with the mother, it may be that he does not share his income with the family, and we do not want the mother to include this income in her report. However, if the mother states that the husband either pays support or gives the family money even though he is not living with the mother, have the mother include this dollar amount in the report of the income to her family. Mothers should also include in this figure financial support that they receive (gifts or other) from individuals outside their immediate family, such as the mother or father's parents.

Question 30

In previous assessment periods, very few mothers have refused to tell us their job incomes, and we expect that most mothers will easily answer this question. However, if the mother refuses to answer or says that she doesn't know, hand Card 18 to the mother and ask question 31. Some Mothers may feel more comfortable responding to the item on the card. If the mother again refuses respect her wishes to keep this information confidential and move on to language questions.

Question 32

If the mother reports that her family has received less than $5000, ask question 32. Item 32a includes support in any form: housing, food or clothing. Item 32b asks for a specific dollar amount received from these sources. If supports are given for housing, food, or clothing, ask the mother to estimate the value of these contributions in dollars. For example, when contributions of free housing are given, mothers will need to estimate the dollar amount of that housing. If the mother indicates that she reported her full financial support in response to question 30 and she is just repeating that amount in question 32, record as "0". If the mother indicates that a part of this support was recorded under question 30, ask her to estimate the ADDITIONAL income dollar amount beyond that reported in question 30. For example, if in response to question 30 the mother reports $2000 income in child support and then indicates in question 32 that she uses child support for clothing for her family, do not record this $2000 income in question 32. Probe as necessary, "Is there anyone else who provides financial support to your family." The important issue here is that financial support entered in question 32 not duplicate information already reported in question 30. Any information or support reported in question 32 should be in addition to that reported in question 30. Call Lyz Jaeger or Marsha Weinraub if you have questions about this item.

Questions 33 through 41: Languages other than English spoken to child.

The purpose of these questions is to identify whether children are exposed to languages other than English, by whom and to what extent. These questions are broken down into two sets: those pertaining to immediate household members and those pertaining to people outside the child's home. For each set, you will be identifying all relevant people who speak to the child in languages other than English, what languages the child is exposed to, which language the child is exposed to most often, if there is more than one, which person speaks in the most common language most often to the child, and about how much of the time this person spends communicating in this language to the child.

For the purposes of these questions, sign language does count as a language other than English. Modify "speaking" in the following questions as appropriate.

Questions 33a and 33b

This question pertains only to people living in the child's immediate household. For purposes of this question, count the child's household as the one she/he lives in with the mother even if the child lives in more than one household. For household members, include only those people that are always in the household when the child is living there. People living in the child's alternate household or people who only live in the household part of the time that the child is living there can be recorded under Question 37.

If there is someone in the household speaking a language other than English to the child, probe to find out who. Mark all that apply. Remember to probe "Anyone else" until the mother says "no". If no one speaks a language other than English to the child, skip to question 37 which asks about people outside of the home.

In this question, "siblings" includes half and step-siblings. Adult relatives are any persons 18 years of age or older. Siblings over the age of 18 are still coded as "siblings", not adult relatives. Record "Mother's Partner" only if this person is not also the child's father.

Questions 34a and 34b

For question 34a, probe until the mother says "that's all" or the equivalent. Mark all the answers which apply.

If the mother indicates that more than one language other than English is spoken to child, ask question 34b. If the mother insists that two other languages are spoken equally, ask her to choose the one that the child seems to understand better. Mark only one answer here.

Question 35

Do NOT ask this question if the mother indicated only one person in Question 33b. You should, however, record the mother's answer from 33b in Question 35.

If the mother says that two people speak the language equally often to the child, ask her to choose the person who spends the most amount of time with the child. Record only one answer.

Question 36

Insert the person identified in Question 35 and the language identified in Question 34b (or 34a if only one language other than English is spoken to the child).

Question 37

For this question, read all of the response choices. Be sure, however, to skip the response option, "Child's Father", if he is living in the household with the child and mother. Record siblings not living in the child's household under "other adult relative" or "other child relative", depending upon their age (18 years old or younger).

If no one else speaks to the child in a language other than English, mark "None" and go to Checkpoint 6.

Questions 38a, 38b, and 39.

Follow the instructions given for Questions 34a, 34b, and 35.

Question 40

Insert the person identified in Question 39 and the language identified in Question 38b (or Question 38a if only one language).

Checkpoint 6: Child's language (Questions 42 through 45)

The purpose of these questions is to determine to what extent the child speaks a language other than English. You will NOT ask these questions if no one speaks a language other than English to the child.

Question 42

Record "Yes" even if the mother says that the child only knows a few words or phrases.

Questions 43a and 43b

If the child speaks more than one language other than English equally often, ask the mother to choose the one that child seems to know best. Record only one answer here.

Question 44

Insert the language identified in question 43b (or 43a if only one language other than English spoken.

Question 45

Have the mother pick a language, including English, which she thinks is primary. If she asks for a definition of primary, tell her the primary language is the one in which the child communicates most often and most easily. If she still can not decide or considers her child equally fluent in two languages, mark both answers.

Checkpoint 7: Questions to ask if no 33 month Telephone assessment (Questions 46-48)

Questions after Checkpoint 7 are ONLY to be asked if there was no 33 month telephone assessment. We ask these questions about the mother's employment experiences so that we may have a complete history of her work experience even for those times we have missed her.

Questions 46 through 48

The purpose of these questions is to update the employment information for mothers who have missed one or two interviews or phone calls in the months immediately preceding the 36 month assessment point. Here we obtain information about primary and secondary jobs lasting one month or more during the period from the last contact preceding this visit until the child's 33 month birthday. You may need to use additional Work Update grids to record all relevant jobs during this period.

For mothers who were previously employed, you should complete the first page of the Work Update grids with the most recent job information we have from the mother prior to the start of the interview.

Throughout this section, use the definitions of "working", "not working", and "on leave" as given for the Work Update questions in Part 3 of the Standardized Interview. Also, follow the instructions for using change codes from that section.

Because you will encounter uncommon circumstances in trying to update employment over a span of more than 3 months, additional instructions regarding how to record this information onto the Work Update grids are included on Part 6 of the Interview Forms.

I. Interview Section 3

In this section of the interview, we ask about any items from the questionnaires that were left blank or that the mother may have questions about. We ask also for permission to contact the child's medical providers about the child's ear infections, we debrief the mother, and we update addresses.

1. Checking Questionnaires

The Visitor should check the forms for completeness. If there are any missing data, comments, or erroneously completed answers, the Interviewer can ask about these now.

If the mother is not able to read, refer to the section on questionnaires (V) and Appendix D in this chapter for administration guidelines. At this time, the Interviewer should also check the Questionnaire Log to make sure it is complete.

2. Ear Infection Data Collection Procedures

At this point, you will be explaining the ear infection data collection procedures to the mother and requesting physicians names from her. Refer to Chapter 28.5 for detailed instructions as to how to obtain this information.

3. Debriefing

After the interview and questionnaires for this 36-month visit have been completed, give the mother a chance to tell you anything that is important to her that you haven't asked and to ask you any questions about the visit or the study.

Hopefully, this will give the mother a sense that she is an important part of the research process and to give her the chance to express any adverse feelings she may have had about the interview. The interviewer needs to be sensitive to any negative affect in the mother and needs to give the mother a chance to share her feelings. If the mother asks questions about the research hypotheses, paraphrase the information in the consent form and two-week phone call.

4. Address/Phone Number Updates

Finally, the interviewer must update addresses and phone numbers. Then check to be sure the family does not have plans to move. If there is a chance the family might move in the next few months but no definite address or phone number is available, have a card or letterhead with the project address and phone number printed on it, and ask the mother to contact your office if they do decide to move.

It is very useful to have the work addresses and phone numbers of both mother and father as possible back-up contacts. Also, be sure to ask if it is OK to call the mother or father at work.

It is vital to have the names, addresses, and telephone numbers of one or two people who will know where the family is. Sometimes you may feel you are pressing the mother a bit to get these back-up contacts. We cannot overemphasize how important it is to have at least one other person who can be called or contacted if the family suddenly disappears with an unlisted phone number or disconnected phone. Therefore, it is worth "pushing" -- politely, of course -- and perhaps explaining that ours is a very important study and that we want to be sure the family has an opportunity to be included in all phases of it.

Refer to the Operations Manual (Chapter 28.1) for the appropriate Exiting Procedures to follow next.

V. ADMINISTERING THE STANDARDIZED QUESTIONNAIRES

A. General Questionnaire Scripts and Concerns

Before going on a home visit, Questionnaires Set I and II should be made into two separate packets containing the questionnaires in the order described in Appendix C. Please note that you will need to pull out the additional questionnaire for employed mothers in Set II before handing it to the mother, if you ascertain during the interview that the mother is now not employed. Before going on the visit, you will also need to highlight the word "Monthly", using a yellow highlight pen, on Question 6 of Form 15H "Family Finances".

Both sets of questionnaires will be administered to the mothers as complete sets, at whatever point in the visit they are given. Do not hand each questionnaire to the mother as she completes them even if you have time to sit there with her while she fills them out. Simply give the entire packet to the mother and ask her to complete them on her own in the order in which they appear.

After the initial Warm-up period is completed, explain to the mother that you would now like to spend about 20 minutes asking the child some standard questions about what CHILD knows while the mother fills out some questionnaires. Say something like:

> "Now I'd like to spend a short time asking CHILD some standard questions about what he/she knows. While I am doing that, I have some questionnaires for you to fill out yourself. You may remember seeing some of these before. I want to you to fill them out thinking about what is happening right now or how you feel about things at the present time. If you have problems with any of the questions, we can discuss them after I finish talking with CHILD. If CHILD or I need your help, I will ask (call) you. Before filling out each questionniare, please read the instructions at the top of the form".

After giving the mother these instructions, determine where she will fill them out. She can be in the same room with you and the child or preferably in a different room (so long as the child is comfortable). If possible, the mother should be far enough away from you that she and the child are not distracted by one another. Give the packet containing Set I Questionnaires and a pencil to the mother. Be sure she uses a hard writing surface (not a clip board, it wrinkles the Scantron forms). Be sure to ask after the Bracken is completed if she had any questions.

Before the mother actually begins doing the Questionnaires, ask her for any assistance or suggestions you need to arrange the setting for administering the Bracken. She may also need to help encourage the child to begin the Bracken.

Once the child is involved, tell her she can go ahead with the Questionnaires. Under some circumstances, you may need her help to keep the child on task. If so, the Bracken takes priority over the Questionnaires. Your first priority should be to complete the Bracken carefully and validly . If the mother does not complete all the questionnaires before you finish the Bracken, allow her to finish the questionnaire she is working on and tell her you will give her the opportunity to complete the rest of them later. You may finish them up between Sections I and II of the Interview. If, for some reason, the mother is interrupted more than momentarily in the middle of a questionnaire, ask her to look over the instructions and her previous answers before resuming.

If it is your opinion the mother is likely to have difficulty completing the Questionnaires on her own, or is "so interested" in the child's performance on the Bracken that she will be highly distracted it may be better not to have the mother complete the questionnaires while you are administering the Bracken to the child. These questionnaires can be completed between Sections 1 and 2 of the Standardized Interview. If you have formed this opinion you may wish to substitute the following statement for the one presented above in Section V.

"Now I'd like to spend a short time asking CHILD some standard questions about what he/she knows. Since it is important for us to find out what he/she can do on his/her own, it is usually best if the parent does not sit right next to the child. It works better if the parent either sits across the room or leaves the room entirely so the child can tell us what he/she knows in his/her own words. Does that seem OK to you?"

If after you have already introduced this section of the home visit with a statement like that first presented in Section V., you may wish to alter the flow of the visit by saying something like the following.

"Now, if you'd rather wait to do the Questionnaires until after CHILD has finished telling me what he/she knows, we can just go ahead and let him/her finish his/her part and then do the Questionnaires a bit later. The visit may take a little longer, but it's up to you. However, it is important for us to find out what he/she can do on his/her own. Therefore, it is usually best if a parent does not sit right next to the child. It works better if the parent either sits across the room or leaves the room entirely so the child can tell us what he/she knows in his/her own words. Does that seem OK to you?"

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When the mother finishes the Questionnaires merely say "thank you," not "that's great" or even "fine". It is common for people to worry they are not doing Questionnaires "right" (more about that later), so do not use any evaluative words that make them feel that you are judging whether they did it "right" or not. Also, maintain some physical distance if possible so that the mother does not feel that you are looking over her shoulder.

After the mother completes each set of questionnares, say something to the mother like *"Do you mind if I look quickly at these just to see that all the spaces got filled in."* The mother will probably say it is ok then just quickly scan for blanks. Ask the mother to fill them in if you find missing spaces. If the mother says she does not want to answer that question, say "fine" and record on the Questionnaire Log that she refused to answer an item. If she says she didn't know how to answer an item, ask her for her best answer. If the problem is that she does not understand a word, you can define a word for her (more about that later). If the mother does not want you to scan the Questionnaires, ask her if she will quickly scan them for missing items for you. When this is complete (whether you scan it or the mother scans it), place the questionnaires in an envelope so it is clear to the mother that her answers are now out of sight. When you get back to the office if you find missing data that you did not detect, call the mother as soon as possible to get the missing response by phone.

It appears the mother can not read, or if she is taking a very long time (very poor reading skills), you may offer to help her after you finish with the child. Do this only when you really feel it is necessary. You can say something like, "*We would like you to fill these out yourself, but if there's any difficulty, I will be glad to read the questions to you. I'll give you a moment to look at the forms and see what you think.*" For this purpose, always take an extra set of questionnaire forms. Read them to the mother. Help her keep track of where you are on the form if necessary. If possible, let her mark her own copy of the form so that her answers are given as confidentially as possible.

If the mother asks you to read the questions to her, and you know she can read, stress to her the importance of administering these questions in the same way to everyone and that we really need her to read the Questionnaires.

As you check over each Questionnaire, mark on a Questionnaire Log whether blank responses are refused information or if you were unable to check re response on a particular Questionnaire(in which case, it may just be missing data). The log will also have a place to indicate whether you suspect some of the information may be unreliable (e.g. the mother seemed hurried and just whizzed through the Questionnaire, she didn't seem to understand a Questionnaire or certain items well, she couldn't attend well enough to respond, she expressed resistance, she kept asking when the session would be over, she seemed tired of doing the questionnaires and was just trying to get through them, and so on).

When introducing Questionnaire Set II (or Set I if not administered simultaneously with the Bracken), say something like, "Now I have (a few more/ one/two questionnaire(s)) for you to fill out by yourself. Again, you may have seen (these/it) before, but I'd like you to fill (them/it) out thinking about what is happening right now or how you feel about things at the present time. If you have any questions, please do not hesitate to ask me. Before filling out (each/the) questionnaire, please read the instructions on the top of the form." Modify the script according to whether Set I or Set II is being administered.

Instructions for Mothers who don't read

When you reach the questionnaire section, you may say something like:

> "Now I have some questionnaires for us to do together. You may remember answering some of these questions before. I want you to answer these questions about what is happening right now or how you feel about things at the present time. If you have any problems with any of the questions, please let me know."

Be sure to let mothers know that they should ask if they do not know what they are supposed to do.

Read the information at the top of each form to introduce each form to the mother. You do not have to say these sentences exactly. When the mother completes each questionnaire, say "thank you," not "that's great" or even "fine". It is common for people to worry that they are doing questionnaires "right" (more about that later), so do not use any evaluative words that make them feel that you are judging whether they did it "right" or not.

B. Encountering Unusual Circumstances

Several unusual situations have arisen in piloting. What follows are some ideas for dealing with these situations.

1. A mother asks someone else to help with the questionnaire answers (her husband, her mother, a friend): Politely make it clear to her that we want HER best answer and that we are asking the mothers in all families to give these answers. So, to make it comparable from family to family, we need her to answer the questions without consulting anyone.

2. A mother is concerned she doesn't know the "right" answers! Make it clear to her that there are no right or wrong answers. We just want her opinion or best response to the questions.

3. A mother asks you what is meant by "very satisfied" or tries to tell you how she feels and wants you to say whether that represents a "very satisfied" or just a "satisfied": You MUST NOT help her arrive at an answer. If she is confused about the question itself, you can try reading the question to her as it is stated (you may use intonation to try to make it clearer). Give her time to think about it. Allow the mother to be confused, if necessary. Give her a chance to figure it out. If that doesn't

work you may explain the meaning of a word to her if understanding the vocabulary is the problem, but she must decide on the answer. So if she says something like, "What would constitute a very satisfied" or "I feel this way, do you think that is very satisfied" or "my baby does this, would you consider that fretful", reply that she must make that judgment; we are interested in what she thinks. Please see the Operations Manual for more specific rules regarding defining words for mothers.

If words are defined for a mother, please be sure it is recorded on the Questionnaire Log (the word that was defined and how it was defined). However, note that defining words is discouraged; defining words early in the protocol will encourage mothers to ask more and more questions. We want to encourage the mothers to use their best judgment. Even so, in cases in which you feel the mother's response would be invalid because she does not understand the meaning of a word, you may define that word for her. Some suggested definitions are given in the following sections. Try to use the definitions given.

4. A mother is filling out a questionnaire incorrectly. She might for example, write down the number of her response, instead of blackening the space. If you see the mother filling out the questionnaire incorrectly, stop her and tell her again what we need her to do. If the mother is marking too lightly, you may want to ask her to make her marks darker. Forms should be checked before being sent to the data center. Responses should be darkened, if necessary.

5. A mother expresses negative feelings about a questionnaire or a particular question (i.e., says the questionnaires are redundant, silly, trivial, or don't apply to her). You should be accepting of the mother's opinion, but DO NOT convey the impression that you think a questionnaire or a question is dumb, silly, or trivial. DO NOT be defensive and DO NOT try to defend any specific measure or question. You may want to say something like, "Some questions may not be as relevant for you as for other people. Because this is a national study, we see many different types of families. For some families, this may be a relevant question. Please answer the questions as best you can". If the mother seems offended by any question, supportingly remind the mother that she may refuse to answer any question.

6. A mother wants to change the order of the questionnaires or do some and not others: You should tell the mother we need to do things the same way with each family, so we need her to do the forms in the original order and we want her to do all the forms. However, remind her that if there is anything that she doesn't want to answer, she doesn't have to answer it. If she insists on doing things in a different order, allow her to complete the forms her way. Indicate on the protocol that the order was changed and how.

7. The mother needs to leave and she hasn't finished all the questionnaires or she's tired and wants to stop, but says she will fill out the other forms later and mail them in: You should

encourage the mother to finish, but don't push too hard, it's not fair to the mother and we don't want poor data. You may give her the remaining forms and a self-addressed stamped envelope (which you should always have) for her to mail back. Ask the mother to complete the forms by herself in the order they are given to her. Stress to the mother that you will need to receive the forms within a week. Call to remind her if you have not received them within four days. Pay the mother for the visit only after the receipt of all materials unless it is not her responsibility that the visit had to be curtailed.

C. Scripts and Problem Solving for Specific Questionnaires

The Questionnaires are:

SET I

1. My Feelings (Form 15D)
2. Parenting Experiences (Form 15I)
3. Relationships with Other People (Form 15F)
4. Family Finances (Form 15H)
5. Love and Relationships (Part A only) (Form 3I)

SET II

6. What Employment Means to Me (Form 3D or 3E)
7. Combining Work and Family (Form 15G)

The following sections list information/concerns/vocabulary words specific to each questionnaire. This information need only be used with mothers who do not read, as other mothers will be completing these questions independently. For each form there are some suggested definition of key words which you may use to help mothers who have difficulty understanding the words in the questions.

1. Form 15D: MY FEELINGS

Note the misprinting and use the designations above the columns to solicit the mother's responses.

Below are suggested definitions of some key words.

"effort" ... work, try

"depressed" ... low in spirits

2. Form 15I: PARENTING EXPERIENCES

Below are several suggested definitions if the mother has difficulty with the meaning of these words:

"unending" ... never ending

"tied down" ...feeling like you can't get out

"strain" ......difficulty

"conflicts" ...arguments, fights

"companionship" ...company

3. Form 15F: RELATIONSHIPS WITH OTHER PEOPLE

Below is a suggested definition for some key words.

"encouraged me" ... gave me confidence or support

4. Form 15H: FAMILY FINANCES

Note that item 6 should be answered only if the answer to item 5 is "yes".

Many mothers fail to note items h through k. DO NOT call her attention to these items, as this will invade her privacy and possibly, invalidate the standardization of the questionnaire.

5. Form 3I : LOVE AND RELATIONSHIPS (A)

This form should be given only to those women who are married/partnered. If you do not give this questionnaire to a subject, do NOT include a copy of it with the subject's ID in the packet of questionnaires that you send to the data center. If you do, it will be counted as missing data, so don't send them this questionnaire at all if you didn't administer it to the subject.

You should use the following script when introducing this questionnaire: *"This set of statements is about your relationship with your spouse of partner. Please read the instructions carefully at the beginning of the form."*

Below are suggested definitions of some key works.

"neglected" ... overlooked

"unique" ... special

6. Form 3D AND 3E: WHAT EMPLOYMENT MEANS TO ME (A) OR (B)

Version A of this form is for mothers who worked during the last year (Work includes part-time, full-time, or temporary.)

Version B is for all others. If they have not worked during the last year or previously, tell them that Questions 1 and 2 refer to the possibility of a future job.

You should use the following script when introducing this questionnaire: "*In this set of statements, you are asked to rate how you feel about your employment. Please read the instructions at the top of the forms before you begin.*"

Below are suggested definitions of some key words.

"central to my self-esteem" ... very important to how I feel about myself

"self esteem " ... how I feel about myself 7.

Form 15G: COMBINING WORK AND FAMILY

This questionnaire should be administered only to mothers who are employed 10 or more hours per week.

Below are suggested definitions of some key words.

"rewarding aspect" ... good things

"prefer to" ... rather

"resentful" ... annoyed

"conflicting obligations" ... things you need to do at the same time

"competent" ... able to do

Note: text resumes on page 119

VI. AFTER THE VISIT (See Section 28.1 for more complete instructions)

A. Reviewing the Data Forms

After the visit is completed, look over the entire interview form to make sure that each item was completed and coded properly. (In some cases, you may actually be able to check this information while the mother is completing questionnaires.) Before posting the data weekly to the DCC, have another interviewer review the forms to be sure they are accurately completed. There are many opportunities for oversights and a second "eagle eye" may spot them.

B. Documentation

After the home visit, complete the Post Home Visit Ratings (Form 15R), Questionnaire log sheet, Interviewer Report Form and Home Visit Report (39X). In most cases, you will actually be able to complete the Questionnaire Log prior to leaving the home.

VII. ENCOUNTERING UNUSUAL CIRCUMSTANCES

1. If you have not completed asking the information you should schedule another time to visit or call the mother at her home.
2. The mother's partner is female: If the mother defines a woman as her partner, then all questions pertaining to partners in the interview should be asked with respect to this person. Substitute "she" for "he" wherever this is appropriate.

VII. APPENDIX

A: Training and Quality Control for the Standardized Interview

Training and Quality Control for the Standardized Interview

The actual training program, for Research Assistants assigned to the 36-month home visit will vary depending on whether they have already done the 1-, 6-, 15 or 24-month visits and are familiar with the techniques for the structured interview and questionnaires. In September 1993, Dr. Lyz Jaeger will train home visitors on the procedures for the Interview and Questionnaires at the General 36 month home training in Little Rock. Information regarding how to prepare for that training will be distributed to sites in July, 1993. Until then, the following information may be helpful.

1. Training Experienced Research Assistants

All 36 month Interviewers must be re-certified for administering the 36 month Interview, whether or not they were certified at 15 or 24 months.

Experienced visitors should carefully review this chapter as well as copies the interview script and the questionnaires themselves. Following this review period, the Study Coordinator or PI should arrange for meetings of the RAs assigned to the 36-month home visit to discuss any questions they may have and to go over all materials. The interviewers should then role-play the interview with each other, taking roles that try out various family situations (mom at home, mom working at six-months and now, mom returned to work at 33 months, single parents). You may also use this meeting to review any questions on which you think your interviewers might need extra practice.

Then, interviewers should do just the structured interview with someone they don't know (perhaps a family you've used before for pilot-testing), but not one of the formal pilot families -- save them for the "full-dress-rehearsal" of the entire 36-month protocol. Interviewers should tape-record these interviews, then listen to the recording, using the Interviewer Monitoring Form to note any problems. The Study Coordinator should review these taped interviews with the visitors. If there are no serious problems, proceed to the full-dress-rehearsal.

2. Training New Research Assistants

New research assistants will need a complete orientation to the purpose of the structured interview. Follow the training guidelines for the 1-month interview in training new visitors to do the structured interview, especially the role-playing and taped practice interviews. It takes several complete structured interviews before most research assistants are comfortable with the flow of this type of interview, and the guidelines for probing and confirming.

3. Quality Control

We will follow similar quality control procedures for the 36-month structured interview as were used for the 1, 6, 15 and 24-month interviews. Two interviews must be completed and certified as reliable before official data collection begins with each interviewer. In addition, interviewers must tape their first two "live" interviews which will also be monitored. After passing these interviews, the interviewer will tape the first interview of each month. All completed Interviewer Monitoring Forms are to be sent to the DCC as soon as they are completed. The initial two certification Interviewer Monitoring Forms should also be sent to Marsha Weinraub.

The audiotaped interviews will be scored, using the Interviewer Monitoring Form, by the Site Coordinator, or other person designated to maintain the reliability of the structured interviews. The Monitoring Forms should be reviewed with the visitor. If a visitor scores below 190, or has a score below 10 on any single category on the Form, the interviewer will must conduct mock interviews until two consecutive interviews reach the 190/10 criterion again. The first two "live" interviews should also be audiotaped and scored using the Monitoring Form.

In addition, EVERY interview and all questionnaires will be reviewed by someone other than the visitor who conducts the interview to ensure data are recorded correctly and to ensure answers are coded accurately. We recommend that visitors review each other's interviews. We find it alerts visitors to the types of errors that are easily made in this kind of protocol.

4. Cross-Site Reliability

We will follow the procedures used for the 1-month protocol. The Site Coordinator, or other person responsible for scoring the visitors' interviews on the Interviewer Monitoring Form, will receive a packet of criterion Interviewer Monitoring Forms, tapes and interviews to use to establish their reliability.

B: Specific Forms to be returned to DCC

1. Interview sections 1 (15A), 2 (15B), Part 6 (39C), Health Condition Follow-Up (39C-a)
2. Questionnaires
3. Interviewer report forms
    a. Early Childhood HOME inventory.
    b. Post home visit interview with mother
    c. Post home visit ratings of mother-child behavior
    d. Home Visit Report (Form 39X)
4. Bracken Basic Concepts Scale
5. Physicians Health Form

C. Questionnaires

SET I

1. My Feelings (Form 15D)
2. Parenting Experiences (Form 15I)
3. Relationships with Other People (Form 15F)
4. Family Finances (Form 15H)
5. Love and Relationships (Part A) (Form 3I)

SET II

6. What Employment Means to Me (Form 3D or 3E)
7. Combining Work and Family (Form 15G)

D. Forms NOT returned to the DCC

1. Interviewer Monitoring Form (except for those needed for certification and reliability)
2. Questionnaire Log
3. Physician Contact Form
4. Parent Permission for Physician Contact Form

E. Additional Monitoring Instructions

General Considerations:

The purpose of the Interviewer Monitoring Form is to document the reliability of the interviewers conducting the Standardized Interview and Questionnaires as part of the 36 Month HOME Visit. At 36 months, these forms will be sent to the Data Coordinating Center after they are completed by a certified monitor at each site. They will be stored at the DCC as a permanent record of interviewer reliability.

Each form that is required to document the reliability of the interviewer must be sent to the DCC. This includes forms on the first two pilot subject interviews used to certify the interviewer, the first two "real" subjects, and the first interview of each month after the initial certification. In addition, if an interviewer does not pass reliability at any point, forms on the first two "non-real subjects" used to recertify the interviewer and the first two "real" subjects must also be sent to the DCC. A copy of all of these forms must also be kept at the sites.

The monitoring form itself is not devised to provide extensive feedback to the interviewers. For example, only violations of reliability should actually be recorded on these forms. Interviewers need to know both what they do incorrectly and those things that they do well. Therefore, while monitoring provides an excellent occasion to give feedback to the interviewers, we suggest that the monitor also make more extensive notes than those recorded on the actual monitoring forms to share with the interviewers. Also, while monitoring is required on a monthly basis, interviewers may desire feedback at shorter intervals. (Some sites tape all of their interviews so that each one can be gone over if the interviewer has particular questions about certain interviews.) In addition, it is strongly recommended that each interviewer be made as knowledgeable as possible about the actual monitoring procedures, even if they are not certifying to become a monitor of other interviewers. The more explicit and clear these monitoring criteria are to the interviewers, the more they will understand what it is we expect from them.

To facilitate the process of becoming certified monitors, we have developed detailed instructions regarding the use of the monitoring form. These instructions, however, are not meant to replace careful study of this entire chapter. Intimate knowledge of both the interviewing and monitoring procedures is necessary to becoming a certified monitor.

If you have any questions regarding the general monitoring procedures or questions about how to use the monitoring form, please feel free to contact Wendy Robeson or Lyz Jaeger.

F. Instructions on the Use of and Scoring of the Interview Monitoring Form

Lyz Jaeger and Wendy Wagner Robeson

Each category will be discussed as it appears on the monitoring form.

1. READS

This category has lead to the greatest between-site differences in the use of the monitoring form. The following things should be noted in this category:

a. The interviewer reads every question as it is worded, every time she asks the question (unless the interviewer is "confirming" -- see below). On re-reads, interviewers often don't repeat the whole question and they should be deducted points for this each time it happens.

b. The interviewer should read all response choices every time she has to read the options to the mother. Interviewers frequently make the mistake of only re-reading the options which seem closest to what the mother is saying. (This particular type of mistake also borders on becoming a directive probe, but will only be counted under "READS.") Points should be deducted every time that this occurs.

c. Also included under this category is how the interviewer states the information in parentheses. There are several different types of information in parentheses:

1. If CHILD/HUSBAND etc. is in parentheses, the interviewer should read the proper name of that person. Points are not deducted for saying 'your child' instead of the name but if the interviewer fails to say the name consistently, it should be noted to the interviewer.

2. If the information in the parentheses is a definition of the intent of the question, then it should be read to every respondent and should be read exactly as it is written when the question is first asked. For example, see Section I, Q# 23. Points will be deducted for not reading this information exactly as it is written.

3. In several cases, information that may or may not be relevant to a particular family is printed in parentheses. This information must be read if it is applicable to a particular family or else points will be deducted. For an example of this type of case, see Section I, Q# 26. (See also Section I, Q#27 -- The parentheses should not be read if the mother reports that her child did fully wake up.)

4. In many questions, the parentheses call for the Month of the last visit or call. A change that will be made in the manual will instruct interviewers to say, "...when we last visited/spoke with you" or "Since I last came to see you in _____" EVERY time the question states "Since MONTH". So the correct way of asking a question that begins with this phrase is: "Since May, when we last spoke with you,..." or "Since I last

spoke to you in May". The interviewer must add this phrase each time the question specifies "Since MONTH".

Points will be deducted if the interviewer inserts the actual date of the previous visit or call in the context of an interview question. Interviewers are instructed to give the actual date of the last call or visit at the very beginning of the standardized interview and questionnaires. They may repeat this date during the transitions to a particular set of questions. In addition, if the mother asks when the last contact was made the interviewers can include the exact date when she re-reads the question.

The only time interviewers should not be adding the phrase, "Since we last visited/spoke with you...", is when there is missing data from the previous contact (call or visit). In this case, the interviewer should just be inserting the month of the child's 24 month or 33 month birthday. For further information regarding how to administer the interview when there is missing data from a previous contact, please see directions under "Interview Section 1" in this chapter.

d. Adding words to the question, especially in the middle of the question or at its end, counts as a violation of "READS" and points should be deducted for it even if it seems trivial. Sometimes, however, some questions can be prefaced in a way which does not count as a violation of "READS". For example, adding the word "And" to the beginning of the question or making a transition statement to a group of questions which has a clear ending before the question is asked (e.g. "This next set of questions also deal with your employment situation". "How many of your...") (Interviewers are expected to make their own transitions between sections of the interview.) However, if the statement prefacing the question could conceivably alter the meaning of the following question, then it should be counted against reliability.

e. Omitting words should be counted as a violation of "READS" even if it seems very minor. For example, interviewers frequently left the word "up" off of Section I: Q:26. While this word does not change the meaning of the question, it does change the way it sounds and may affect how the mother hears the question.

f. Interviewers frequently fail to read the Work Update prompts exactly as they are written. Points should be deducted if they fail to do so.

g. The transition sentences in the interview do not have to read exactly as written. However, some sentences that used to be part of the transition scripts are now part of the question. See, for example, Section I: Q31 and Q35. These statements should now be read exactly as worded because they are now part of the question and if they are not read as worded, points should be deducted for reliability.

h. While it is useful to note every instance in which the interviewer has not read every question exactly as is written (except where they otherwise confirmed the information), the following do NOT count as errors under READS:

1. If an interviewer reads two words as a contraction rather than as two separate words, no points will be deducted. Be especially careful, however, that the interviewer does not inadvertently change the tense of the sentence. If this happens, points should be deducted for reliability.

2. If an interviewer prefaces questions with a word like "And" OR "Next". If the interviewer does this frequently, it is worth noting to the interviewer but will not count against reliability. Be careful, however, that the interviewer is not inserting words before the question that may alter its meaning. For example, adding "On Average" before a question changes the meaning of that question EVEN IF that is what is the implied intention of the question. If the respondent needs help remembering that something is "on average", the interviewer should read the question as is, and then "step outside of the interview" to clarify that the question is about "on average".

3. Changing prepositions such as "spoke to you" versus "spoke with you" does not count against reliability.

4. Changing articles such as "this" to "that" will not count against reliability.

5. Inserting the word "that" after the words "Would you say" will not count against reliability. See, for example, Section I: questions #31 and #35.

6. In the Work Update prompts, the TAXES prompt may be read "Is this before taxes?" and no points will be deducted for reliability. This change was made because the question printed on the grid is not consistent with the question on the prompt sheet.

7. In Section II: Questions 23-28, points will not be deducted if interviewers do not read the phrase "Please choose one of ..." exactly as it is written.

8. And as already mentioned above, points will not be deducted if the interviewer says "your child" in the place of the child's name when the question states "CHILD".

Please NOTE: There are two questions printed on the interview form which are NOT to be read exactly as they are worded under certain circumstances. Points should be deducted if the interviewer does not make the applicable modification.

1. Section I, Question #23: This question needs to be modified if the mother reported any special needs at the 24 and/or 15 month Interview. Please refer to the description of procedures in this manual for the correct phrasing of this question.

2. Section I, Question #32: This question should be modified to read, "Are these still a problem?", if the mother reported 2 or more previous chronic conditions. Interviewers must use this exact phrasing when asking the question.

There has been considerable controversy regarding how much and when interviewers should adhere to the "READS exactly" rule.

Remember, interviewers can choose to CONFIRM (see below), "step outside the interview", TRAIN the respondent, and PROBE. All of these make the interview more "friendly" and accurate. If you have interviewers who are making consistent READS errors which you think are trivial, please discuss them with Wendy Robeson.

It is rare for interviewers to have flagrant violations of this rule. Usually the mistakes are small, such as omitting or adding one word to the sentence. Even though these mistakes can look small, they often have subtle, yet quite conceivable, implications for the meaning of the question. While this rule may seem strict, it is important to note that many interviewers easily get to the point where they do not commit these errors and even if the commit four of these types of errors, they still pass reliability!

2. CONFIRMS

The only errors that are to be recorded here are those made when a question is confirmed rather than read exactly as it is written. Some people have put failure to confirm errors under this category but that is not the intention here. What we are really concerned with under "Confirms" is WHEN the interviewer does use confirmatory statement, do they use the meaning containing words in the original question.

A frequent error made by interviewers is that they attempt to confirm a mother's answer before they have enough information. Any case where an interviewer does not have full, clear information from the mother prior to asking the question, they should NOT confirm. If they do, this becomes a directive probe error and should be recorded as such.

A common mistake noted on the 15 month Interview was that interviewers were frequently confirming whether or not the mother moved since the 6 month visit. They were assuming that if the mother is at the same address, that she has not moved. This is incorrect. She easily could have moved and moved back in again since that time. This error would be scored as a PROBE error since it is a directive probe.

If an interviewer is confirming a question because of information heard prior to the Standardized Interview portion of the visit, they should repeat this information before they confirm the question so that the monitor will know that the interviewer actually had this information. For example, if the interviewer finds out earlier in the visit that the husband is no longer employed, the interviewer could say something like, "When we were talking earlier in the visit, you mentioned that your husband is not now working for pay."

3. DEFINES

This category refers to definitions that the interviewer gives the mother during both the interview and the questionnaires. Errors to be included in this category include offering definitions of subjective phrases to the mother, giving incorrect definitions of words for which the interviewer is allowed to give a definition, not giving the manual definition of a word if it is defined in the manual, and failing to note definitions given on the Questionnaire Log.

4. RECORDS

There has been confusion over the use of this category and the "CODES" category. Errors noted under "RECORDS" generally refer to recording errors on questions where the interviewer must record exactly what the mother tells her in the form of pre-existing Scantron" bubble choices. The interviewer has to make no coding decision on these types of questions. Answers are either recorded as given or codes, such as years of schooling.

Common recording problems with the 15 month Interviews were that interviewers forgot to fill in the NA box for the secondary job in Section II: Question #2 and they also failed to fill in N's on Section I: Question #22, where applicable.

5. CODES

This category refers to questions where some coding decision is required by the interviewer. These questions are generally asked as open-ended questions and the interviewer determines which Scantron answer represents what the mother has said. The relevant items on the 36 Month Interview are: Section I: question #22 - 4c, 4d; question #23; Section II: Occupation code on Work Update, question #13, question #22). (Also, if Section I: #22 is asked simply as an open-ended question and answers are not confirmed with the mother, then potential errors in coding would also be noted here.)

The interview also calls for the recording of information that is not in the form of a Scantron answer. There are many places in the interview, for example, that ask the interviewer to "Specify". Although these answers may not seem as important as the Scantron answers, the answers to these questions should be recorded clearly and in a form that would be interpretable by someone other than the interviewer. If the interviewer consistently fails to record such information clearly over the course of the interview, count this as one instance of a disagree.

6. FAILS TO PROBE

A difficulty in noting these types of errors on the monitoring form is that they are likely to be confounded with recording or coding errors. Interviewers make coding and recording errors often because they do not have enough information, i.e. they failed to probe where it was appropriate. For purposes of the monitoring form, we will not double code interviewer errors. If a recording error is really the result of a failure to probe, record it only as a failure to probe. (If the recording error is the result of some other problem, record it under "RECORDS" or "CODES".)

Common probing errors include the following: 1) not getting sufficient information to record the mother's response exactly in the form that the Scantron options call for (for e.g. coding a Y or N response when the mother has not actually said either yes or no), 2) not probing "Anything else?" on all open-ended questions (such as with section I, questions 22, 33, 24, 36-40) -- failure to probe one question of this type will not result in deducted points but failing to do this twice or more will count as one failure to probe error and 3) not resolving factual contradictions during the course of the interview -- each error of this sort should be noted.

Also, please note the new probing instructions regarding Section I, Q #34 as explained in this manual. If the mother gives a response such as, "Yes, for a regular exam.", the interviewer is expected to do more probing. Failure to probe this type of answer should result in points deducted.

7. PROBES

Directive probes include any questions that may prejudice the mother's answer in any way. For specific examples, please consult section III.A.4. of this manual.

There are other types of inappropriate probes that are not necessarily directive. For example, if an interviewer asks a mother the same question twice and the mother has previously provided an answer that fits into one of the acceptable response options, re-asking the question is an inappropriate probe. However, if the interviewer has clear evidence (i.e., an answer to an earlier question, the mother's statement that she doesn't understand the question or is unsure of her answer), repeating the question is often the best approach. Put simply, if interviewers have "evidence" of inaccuracy or confusion, it is okay to repeat a question. If they don't have evidence, they shouldn't repeat "just on a hunch".

All instances of directive and inappropriate probes should be noted in this category. Also count here when an interviewer answers a mother's question incorrectly or in doing so interprets the meaning of a question for her where no other information exists to do so.

8. SKIPS

Several different types of errors should be noted under "Skips". Failure to follow skip patterns, and failure to ask or confirm any single question that should have been asked are all included under "skips".

An interviewer should generally not be penalized for getting too much information. The only exception to this is when the interviewer asks questions about a husband/partner when the mother does not have a live-in husband or partner. Asking such questions is likely to compromise rapport.

A question which many interviewers have had is whether a skip problem that is soon corrected by calling the mother and getting the missing information should be counted against reliability. The answer is yes, these errors, even if soon corrected by the interviewer count as a "SKIP" error. The interview is meant to be given in person, not over the phone. Also, calling the mother back is another imposition on her time which we should seek to avoid. IF, however, the interviewer catches their skip error before leaving the home and records these questions being asked of the mother, it should NOT be counted as a "SKIP" error.

One common problem noted with the 24 month pilot interviews was that interviewers were failing to confirm the relationships of the household members to BOTH the mother and baby. If these are not confirmed, it should count as a skip error. Another common problem was that interviewers fail to confirm information especially when the mother answers the question in her answer to the previous question. Even if this happens, the interviewer is expected to confirm the information rather than to skip the question altogether. This is especially common with Section I: questions 20-22.

Another common skip error on the Standardized Interview is to fail to ask the mother to "specify" her answer (e.g. Section I, Q# 17) or for other additional information (e.g Section I, Q# 36-39 -- WHEN?). While this information is not recorded in a Scantron format, it is still important information and should be asked. (If these type of questions were asked, but no answer is written in on the interview forms, this will count as a RECORDING error.)

9. FEEDBACK

Interviewers must seek to avoid saying anything to the mother which may make her conscious about what the interviewer feels or thinks. Anything which conceivably could compromise the neutral context of the interview will count as a feedback error.

Several problems are common in this domain. First, interviewers still use words such as "O.K.", "Alright", etc. as filler between questions. While we are certain that many times mothers would not interpret this as an interviewer's evaluation of the mother's answer, we can never be sure that she won't interpret these words in that way. Thus, they are better avoided. (Also, when an interviewer uses these words repeatedly, she can sound as though she is cutting the mother off from offering additional information and trying to rush her through the interview). Each instance where this type of word is used counts as a feedback error.

A second problem that is common is that interviewers frequently want to say positive things to the mothers, particularly after they have expressed delight about something. For example, mothers are often happy to report that their babies had no health problems. Interviewers are likely to respond with statements such as "That's great". Unfortunately, what this seemingly nice comment may be doing is telling the mother that the interviewer would much rather hear about positive things rather than negative things such as health problems. Perhaps the best thing that an interviewer can do when a mother expresses delight or happiness is to "match" the mother's affect. For example, if the mother is smiling, the interviewer may smile too.

A third problem that interviewers have encountered is what to say if the mother expresses something that may seem very sad. In these circumstances, interviewers often want to offer words of sympathy. While this may seem like the polite and rapport-building thing to do, in some cases, the last thing the mother wants is for the interviewer to focus in on the issue by saying something about it. And, again, if the interviewer appears sad by what the mother has told her, the mother may censor other responses so as to not affect the interviewer's feelings. As with happy news, it is appropriate to match the mother's affect. If she appears sad, its okay to say "I'm sorry to hear that" and then continue the interview. It is important to emphasize that non-verbal behavior may be even more effective at expressing concern and respect for the mother's feelings than what the interviewer may actually say to the mother. Words are no substitute for sensitive, attentive listening particularly when the mother is discussing something distressing or of grave concern to her.

10. TRAINING

Training needs to occur both at the beginning and during the interview. One of the most common problems with training is that interviewers do not do enough of it, particularly with mothers who interrupt the interviewer. If a mother interrupts the interviewer two or more times while she is trying to read all of the response choices, the interviewer should train the mother by explaining the nature of the question. If the mother interrupts and the interviewer fails to train her more than once but less than four times, the monitor should deduct at least 10 points from the "Training" Score. If the mother interrupts four or more times and the interviewer fails to train her, the TRAINING score will be zero. In considering how to score this category, think of whether of the interviewer has made the mother's job as easy as possible.

11. PACE

This issue has not presented much of a problem for interviewers but a few things are worth keeping note of when scoring this category. First, make sure that interviewers are not speeding up as they read the response options. Second, make sure that even if the mother seems to be understanding everything, that the interviewer's pace is not too fast. Often, mothers want to rush through the interview because they have a time constraint and the interviewer speeds up to try to accommodate the mother. Instead of compromising the reliability and validity of the interview by reading the questions too quickly, the interviewer should tell mothers in this circumstance that they will try to complete as much of the interview as possible but that it might be necessary to either call her or visit her again.

CHAPTER 28

Section 5

PROCEDURES FOR COLLECTING EAR INFECTION DATA

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CHAPTER 28

Section 5

PROCEDURES FOR COLLECTING EAR INFECTION DATA

I. OVERVIEW

You will see that the procedures described herein allow a restricted set of choices for the collection of ear infection data from the physicians.

All of the procedures for each option are outlined below. Also provided herein are descriptions and directions for updated and new forms that will be required for this data collection process.

II. BACKGROUND INFORMATION

Otitis media is the medical term used to refer to a collection of fluid in the middle ear. Children who have ear infections have this fluid which may or may not continue to be present beyond the infection itself. During episodes of ear infection the presence of fluid in the middle ear may cause some depression of hearing level. Frequent episodes of otitis media with hearing loss may result in a delay in some aspects of the development of speech and language, sustained attention and peer relations. Therefore, it is important to collect information about this infection history from as many children as possible.

Feagans (personal communication) claims that maternal report is an unreliable measure of ear infection and otitis media history. Regular physician checkups and audiometric testing are optimal but may be cost prohibitive. Thus, we have chosen an alternative means for gathering this important data. We will be obtaining permission from the mothers to contact their child's medical provider(s) to ask for information about ear and upper respiratory infections only. Once permission is obtained, we will be requesting a medical history of upper respiratory infection, ear infection, and otitis media on each study child.

III. OPTIONS FOR DATA COLLECTION

The common protocol procedures for otitis media data collection at 15 months were differentially effective when applied across the country. Smaller towns tended to have subjects concentrated in a few medical practices. In larger cities the subjects were more dispersed. The effect of this difference was that physicians in the smaller communities felt overwhelmed by the sheer number of forms to be filled out.

In response to this varied impact on the amount of data collected around the country and because this data is considered crucial to interpretation of the common protocol outcome measures in cognition and language, a new procedure is being implemented at 36 months.

Various sites have requested flexibility in mode of data collection. In response, the following 3 data collection procedures are suggested as optimal. In each case the mission is the same as stated below. Sites have the opportunity to contractually sign-off with the Temple Site for one of these 3 options. If for any reason, sites would like to change the procedure suggested, they must do so with approval from the Temple site.

General Mission: Our goal is to collect as much of the Otitis media information as we can for all children upto and including 36 months of age. This means collecting all information noted on the short form of the Physician Health Form supplied in the 15 month manual and again in the 36 month manual. The information must be collected from all and any doctors who the mother has given us permission to contact at 15, 24, and 36 months (forms 15L-b, 24L-a and 39L-b

1. **Option 1** - Simultaneous Collection: same as 15 month procedures. Letters and forms are sent to physicians during the ongoing process of data collection. That is, Otitis Media data is collected simultaneously with other CP data at 36 months.
2. **Option 2** - Simultaneous Collection with reimbursement: This is like the simultaneous condition above with the addition of a monetary remuneration for the physicians.
3. **Option 3** - Post Common Protocol Collection: with nurses hired by the individual sites who will go to the physicians office and do the data collection after all of the 36 month home visits are completed.

IV. PREVISIT PREPARATIONS

This section outlines a procedure for determining which subjects will actually provide ear infection data. The ear infection data, for each subject, are complete only if we have them for each period of data collection. Thus, if the mother gave permission to collect data at 15 months, but efforts to get the data from the physicians failed, then, depending on the doctors' responses, further attempts *may* be made. SEE FLOW CHART.

Regardless of the option chosen by each site for data collection from the physicians, several preparation procedures are necessary before any of the mothers or physicians are approached for the data collection at 36 months. These are outlined below. **All sites must follow these procedures.** Please read through it carefully and follow the instructions in detail.

1. Appoint an ear infection coordinator for your site. This person is responsible for a) reading through the ear infection section of this manual very carefully; b) instructing the home team on the procedures including having them read this manual. c) familiarizing him/her self with the process of ear infection data collection at his/her site. (e.g., What was the prior return rate of 15 month forms? Which forms are available for physician report from prior visits (Physician Contact Forms,15L-a, 24L-a)? Were there any earlier complaints or complications in return rate, etc.? d) choosing an option that will optimize data collection at her/his site in collaboration

with the PIs and Site Coordinator.

2. The coordinator should then review the Physician Contact forms (15L-a and 24L-a),the 15 month follow-up form (15L-b) and the data returned by the doctors (short and long forms). This person should then compile information on the status of each subject regarding his/her history with respect to ear infection information by completing the Ear Infection Follow-up form [39L-b (1,2,or3)].

Therefore, it will be clear for each subject what occurred with regard to the ear infection data collection at 15 and 24 months. And there will be information pertaining to

(a) whether the mother gave her permission for data collection and gave the site her child's physician's names. If she did, then the names of those doctors will be on forms 15L-a and 24L-a (The Physicians Contact Form).

(b) if she refused to provide the names, when did she refuse? at 15 months, at 24 months?

(c) whether the doctors complied with the site's data collection requests.

(d) what data were collected for each subject.

Thus, before the home team visits the mother for the 36 month data collection period they will be fully informed about the subject's ear infection data collection status. This information should be recorded on form 39L-b. Make sure to use the 39L-b form that is consistent with the data collection option that you have chosen: Option 1 (39L-b1). Option 2 (39L-b2), Option 3 (39L-b3). Note the subject number is to be recorded on the upper left hand corner of this form. On the basis of the status of ear infection data collection for each subject a determination can be made concerning the collection of this data at 36 months.

3. Follow these guidelines to complete form 39L-b in order to proceed with the data collection at 36 months:

a) If the mother did not give her permission to collect the data at 15 or 24 months then circle N when asked "Is this a subject for ear infection data?" Check "mom refused" to the question "why not?" and indicate refusal period: 15 mos or 24 mos.

(Note: This subject will constitute missing data from your site. This will be noted on the OM Data Collection Summary Sheet (form 39L-J).

The mother **should not be contacted further** with regard to ear infection data. Proceed no further in the ear infection manual **for this subject**. That is -- do not request the names of physicians at 36 months for this subject.

b) If the mother did grant permission and the doctors did not return the forms, proceed by filling out form 39L-b (1, 2, or 3) and by copying all information on all doctors from 0-24 months onto this form. (From forms 15L-a and 24L-a)

Note that if a physician has been contacted before and did not reply, then a special letter will be sent to this doctor (See section e). At this point it is only important that all of the relevant information be recorded on form 39L-b (1, 2, or 3) so that new names can be added and all doctors can be contacted.

c) If any of the physicians openly refused, that is, they stated that they would not participate and complained to the site, note this fact on form 39L-b (1, 2 or 3), at the top - right under b. If your site has chosen a different form of data collection than that used in the past (either option 2 - Simultaneous with Reimbursement or option 3 - Post Common Protocol Collection), then **proceed with data collection** and note on form 39L-b (1, 2 or 3) that the doctor had been contacted before (under 15 month history section).

If any of the physicians openly refused to participate and complained to the site, and the site has decided to continue with Option 1 - Simultaneous Data Collection, then that physician will not be contacted again and no data will be collected for this subject at 36 months. Write the subject number on form 39L-b (1, 2 or 3). To the question, "Is this a subject?" circle N for no. To the question "If no, why not?" respond, doctor refused to give us the data. Note a subject is dropped after one or more physician refusal(s) ONLY if Option 1 is chosen by your site for data collection. This subject will count as missing data from your site. Do not proceed with the instructions in this part of the manual for this subject. The mother should NOT be contacted further with regard to ear infection data. The names of the subject's physicians from 24-36 months should NOT be collected. This subject's data will constitute "missing data". This status will be recorded on the OM data collection sheet (form 39L-J).

d) **To recapitulate:**

1. look at all data from prior forms 15L-b and 24L-a and subject files before 36 month data collection begins.

2. Fill out 39L-b (1, 2 or 3) with relevant information about mother refusals or physician refusals. *This must be filled out prior to contacting the mother at the 36 month home visit.* If the mother refused to give us the data at either 15 or 24 months. DO NOT COLLECT DATA AT 36 MONTHS. This subject is unusable.

3. If the mother gave permission but any of the doctors listed openly refused to participate, ask the following question.

a) Is our site using Option 1 - Simultaneous Collection? If yes, then note that at least one doctor refused on form 39L-b (1) and DO NOT COLLECT DATA FOR THIS SUBJECT AT 36 MONTHS.

b) Is our site using Option 2 - Simultaneous Collection with Reimbursement or Option 3 - Post Common Protocol Collection? If yes, then proceed with 36 month data collection.

4. If the mother gave permission at 15 & 24 months but the doctor simply did not send in the data, note the names of all physicians from 0-24 months on form 39L-b

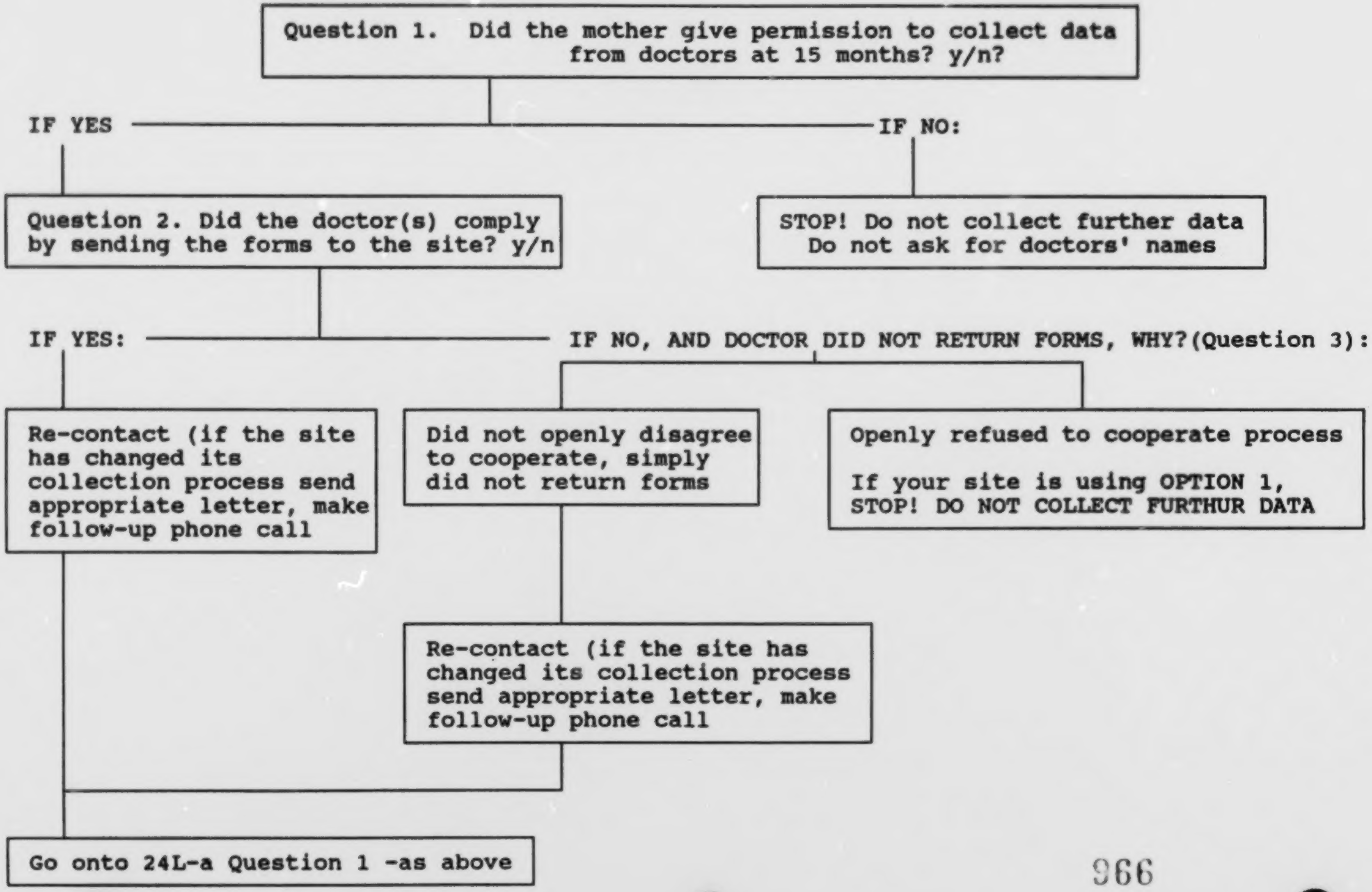
(1,2 or 3). Proceed with 36 month data collection.

5. If the mother gave permission and the doctors returned the data note this under physicians' names for 0-24 months and 36 months on form 39L-b (1,2 or 3). Proceed with 36 month data collection.

4. The Ear Infection Coordinator will give the home visitor the completed follow-up form (39L-b) for each subject. With this information the home visitor can determine what, if any, data are needed at the 36 month visit.

Pre-visit preparation FLOW CHART for data collection at 36 months

Note: using forms 15L-a, 15L-b, 24L-a and 24L-b a determination can be made concerning further data collection



Question 1. Did the mother give permission to collect data from doctors at 15 months? y/n?

IF YES

Question 2. Did the doctor(s) comply by sending the forms to the site? y/n

IF YES:

Re-contact (if the site has changed its collection process send appropriate letter, make follow-up phone call

IF NO, AND DOCTOR DID NOT RETURN FORMS, WHY?(Question 3):

Did not openly disagree to cooperate, simply did not return forms

Re-contact (if the site has changed its collection process send appropriate letter, make follow-up phone call

Openly refused to cooperate process

If your site is using OPTION 1, STOP! DO NOT COLLECT FURTHUR DATA

Go onto 24L-a Question 1 -as above

IF NO:

STOP! Do not collect further data
Do not ask for doctors' names

V. HOME VISITOR PREPARATION and SCRIPT

Prior to 36 month data collection, the home visitor will receive from the ear infection coordinator the completed follow-up forms [39L-b(1,2,or3)] for each subject. This form tells the home visitor which, if any, data need to be requested from the mother and/or doctors. After receiving this form the home visitor should prepare a Physicians' Contact Form (39L-a) for the visit if it has been determined that data are to be collected on this subject. The home team must circle the appropriate data collection period on the top of the Physicians' Contact Form (39L-a) - 0-36 months if no names were given prior to this collection period, or 24-36 months if mother gave all doctors' names up to this collection period. Remember, we need to know about all medical providers from 0 - 36 months to have completed data. The visitor must take the Physicians' Contact Form (39L-a) and the completed copy of the follow-up form (39L-b,1,2,or 3) on the visit in order to respond to any questions the mother may have.

After finishing checking over Questionnaire Set II, during the visit, the home visitor should explain to the mother about the ear and upper respiratory infection data collection and ask her to fill out the Physician contact permission form. The script for giving this information is as follows:

> *"The last form we would like you to fill out today concerns your child's health records. Throughout the study, we have been asking questions about CHILD'S health.*

Most of these questions you as the parent can answer directly but there is one area having to do with ear infections and upper respiratory infections about which we would like to get additional information from your child's medical providers.

We are particularly interested in the ear and respiratory infection histories of all the children in the study because these infections are so common among children in the preschool years. Specifically we will be requesting information about the number of occurrences of ear infections and upper respiratory infections and the presence of fluid in the ear during and following the time of infection. This is the only information we will be asking the doctor or clinic to provide.

Your participation in this data collection is completely voluntary. If you are willing to give us permission to contact your child's medical providers, please take a moment to fill out these forms. Thank you."

If the mother has given permission to contact the doctors, then give her Form 39L-a, the Physician Contact Form to get the names, addresses and phone numbers of the child's medical provider(s). Remind mother that we need the names of all providers used from the time frame (0-36, 15-36, or 24-36 mos.) whichever was circled at the top of form 39L-a.

After the home visit the home visitor should immediately transfer the names of physicians listed on form 39L-a onto form

39L-b (1, 2 or 3). When the mother has given the site the subject's physicians' names from 24-36 months, or other periods (Form 39L-a) add them to this list of physicians to be contacted at 36 months. Then a copy of form 39L-b(1,2,or 3) should be given to the person responsible for overseeing the collection of the ear infection data (either the ear infection coordinator or a home visitor). That person will collect the data, by the means described below, from all of the doctors listed on the follow-up form [39L-b(1,2,or3)], including those who did not provide data at the 15 month collection period.

VI. DATA COLLECTION PROCEDURES FOR ALL OPTIONS

A. Option 1: Otitis Media Data Collection - Simultaneous Collection at 36 Months

1. In the preparatory section of this ear infection manual, the ear infection coordinator entered the child's name and ID number, all names of medical providers supplied by the mother up to 24 months, their telephone numbers and whether they had received and or returned completed forms onto the Ear Infection Follow-up form 36 L-b (1, 2 or 3). Once the mother has provided the names of physicians from 24-36 months, these physicians names were added onto form 39L-b (1, 2 or 3) which should now have a complete record of all physicians noted by the mother. This form will be used to record the date that the form is mailed, the date a follow-up call is made (if necessary) the date that the form is returned and the date the data are sent to

the DCC. The Ear Infection Follow-up form must be kept in an accessible file for easy retrieval. Make sure that any physician names previously recorded for 0-24 months had previously been copied onto this form, along with the names for 36 months, so that all information is readily available.

2. Prepare a letter to the medical provider(s) with the appropriate information as indicated in Appendix D, Sample Letter to Physicians, Version 1. If the physician had been contacted before use Sample Letter to Physician, Version 1b [or 2b and 3b for other options]. Fill in child's name and birth date and coding period (either 0-36 months, if the physician never completed a form before or 15-36 months, if the physician had completed a prior form up until 15 months.) On the Physician Health Form note subject ID number is not filled in until after the form is returned to the site. Make copies of the parent's permission form. Keep the original in the Ear Infection File and send out the copies to the medical providers.

3. If your site is in a small community in which a few doctors or clinics are going to be receiving a large number of these forms, it might be helpful to call and enlist the doctors' participation prior to mailing the forms. It is a good idea to explain to the doctors that this is an NICHD Study of Early Child Care and that their cooperation will enable us to learn more about the incidence and possible effects of Otitis Media in children during the preschool years. You might suggest that if they are interested in speaking with the national project

coordinator they are welcome to. You could provide your PI's name and phone number if s/he agrees.

4. Mail the appropriate letter to new physicians - letter versions 1a [2a and 3a for other options] or previously contacted complying physicians - letter versions 1b [or for other options 2b or 3b] or previously contacted refusing physicians versions [for options 2 and 3 only 2c or 3c] to the Physician, the Physician Health Form - Short (Form 39L-c) [note whether the doctor returned the form for the 15 month data collection period. If no form was returned write the child's birthdate in the appropriate space on the cover sheet of the Physician Health Form-Short (36L-c). If the form was returned write in the date of the last visit to the doctor, as recorded by the doctor, in the appropriate space on the cover sheet. The doctor does not need to report visits previously reported.], and a copy of the parent's permission form to each medical provider listed. Record the date sent on the Ear Infection Follow-up forms (form 39L-b 1, 2 or 3). (Each site can determine the most efficient method of mailing the physicians' letters and forms. It may be that doing one mailing each week will be more efficient than sending them out after each home visit.)

5. Forms returned within two weeks should be dated and recorded on the Ear Infection Follow-up form (39L-b 1, 2 or 3). Someone at the site will need to transfer the information from the short form (39L-c) to the original long scrantron form (15L). Note that the short form does not ask for as much data as the

long form, and therefore some questions on the long form will be left blank. Also, the short form requests information about myringotomy (implantation of drainage tubes). The information about myringotomy will not be coded on the long scantron form. Also, since the doctors indicated that they do not like the bubble forms, the information was not requested in that fashion. RA's will have to fill in the bubble information from the data given. DO NOT TRANSFER INFORMATION FROM MEDICAL RECORDS if these are directly returned by doctors (employ a trained nurse to do it).

6. Forms not returned by the end of two weeks require a follow-up phone call to the medical provider(s). It is not necessary to speak to the doctor personally since in most instances, it is the nurse who fills out the form. Indicate that the child for whom the form was sent is part of an NICHD Study of Early Child Care and that the information we have requested will provide us with important data about the incidence of ear infections, upper respiratory infections, and otitis media in the preschool population. Ask if the doctor's office has received the form, and if not, offer to send them another one. If the form has been received, ask when they may be able to return it. The date of the follow-up call should be recorded on form 39L-b (1, 2, or 3). Receipt of forms following this call should be recorded as above.

7. If a doctor refuses to fill out any more forms after completing some, you may want to talk with your physicians over

the phone, or by other means, as you feel is appropriate.

8. If the physician or clinic does not respond after the follow-up call, the ear infection/respiratory infection data will simply not be collected. You do not have to make a second call, unless the physician (her receptionist, nurse, etc.) could not be reached with the first phone call. Do not leave a message on the answering machine.

9. Upon completion, the original Physician Health Form (Form 15L) should be sent to the Data Coordinating Center (DCC) and form 39L-a (Physicians Contact form) and 39L-b(1,2,or 3) (Ear infection follow-up form) should be kept in the subject's file. When information is sent to the DCC, the date that it is sent should be recorded on form 39L-b (1, 2 or 3).

10. When all data are collected from a particular subject, fill out the OM Data Collection Summary sheet (form 39L-J). The form includes subject number and data at 15 months. If there are no data, record why. The form also request information relevant to the 36 month data collection and codes when the data were sent to the DCC. Use form 39L-b (1, 2 or 3) to prepare this summary sheet. Make sure that there is an entry for each and every subject -- whether there are data or not. Keep a copy of this form and send the original to the DCC when the 36 month data are complete.

B. Option 2: Otitis Media Data Collection - Simultaneous Collection With Reimbursement at 36 Months

With this option, the physician or nurse can be paid (as the site sees fit) for completing the form. Proceed as in Option 1 above. At step 4 however, substitute Amended Letter to Physicians, Version 2a if the physician is new and 2b if the physician had cooperated with us before. Form 2c should be sent to physicians who had refused to cooperate before in the original 15 month collection. Then proceed with steps c. - j. as before.

Add Step 12: Send check or money agreed upon to the physician's office and mark date sent on Ear Infection Follow Up Form for option 2 (39L-b2).

C. Option 3: Otitis Media Data Collection - Post Common Protocol Collection (With Nurse or Doctor Going to Office) at 36 Months

Under this option all of the data are collected by a medically trained professional (nurse or doctor) who is hired to record data after all of the common protocol data have been collected at 36 months. The steps to follow for this option are as follows:

1. Enter the child's name and ID number, all names of medical providers supplied by the mother for 0-15, 24 and 36 months, their telephone numbers, and record the 15 month history on form 39L-c. This form will be used to record the date that the visit is made to the doctor's office by the trained personnel and the date the data were sent to the DCC.

2. Prepare a letter to the medical provider(s) with the appropriate information as indicated in Appendix D, Sample Letter to Physicians, Versions 3a, b, c. 3a is for newly

contacted physicians; 3b is for formerly contacted physicians who returned the data; 3c is for those who refused to cooperate in prior contacts. Fill in the child's name and birthdate and coding period (either 0-36 months if no data were available from 0-15 months or 15-36 months if data were previously available). Copies of the mother's permission form must be sent to each doctor. The original permission forms must be kept in the Ear Infection File.

NOTE: If one physician has a number of subjects, the names of all relevant subjects may be listed on a sheet with copies of the permission slips from each of the parents sent in bulk.

3. Call the physician 4 or 5 days after mailing the letter to schedule a visit at a mutually convenient time.

4. Information collected in this way can be directly added onto the long form (15L). Note that because the short form (39L-c) does not ask for as much data as the long form some questions on the long form will be left blank. Also the short form requests information about myringotomy (implantation of drainage tubes). The information about myringotomy will not be coded on the long scantron form. Finally, those using the long form should be define an "episode" of otitis media as noted on page 1 of form 39L-c, the Physicians Health Form.

5. Upon completion of a visit to a doctor's office, the visit should be recorded on form 39L-b3. The long form for each subject (15L) should be photocopied with the copy stored in the

subject file and the original sent to the Data Coordinating Center.

6. When all data are collected, fill out the Data Collection Summary form (39L-j). This form includes subject number and data at 15 months, etc. If there are no data, record why. The form also requests information relevant to the 36 month data collection and codes when the data were sent to the DCC. Use form 39L-b3 to prepare this summary sheet. Make sure that there is an entry for each and every subject whether there are data or not. Send this form, 39L-J, to the DCC at the end of the data collection period, keeping a copy on file at your site.

VII. THE CONTRACT

The staff at each site is to decide which of these options best suits them for means of data collection in their area. They must then fill out the sample contract listed in the Appendix (Form 39L-I) keeping one copy on file in the Ear Infection file at their site and mailing two to Kathy Hirsh-Pasek at the Temple University site. The Temple Site will keep a master file of what each group is doing. Any deviations from options 1, 2, or 3 must be mutually agreed upon and signed off by both the site proposing the amendment and by the Temple site. The Temple site will co-sign one form that will be returned to the original site. A copy will be made and forwarded to the DCC. Please complete this contract by December 1, 1993.

VIII. TROUBLE SHOOTING

1. What if the mother has the following reservations about your contacting her medical provider(s) for the ear infection information?

a. Mother is concerned about having taken the child to several medical providers. Assure her this is a common practice.

b. Mother is concerned about not having taken the child to a medical provider when the child had an ear infection and/or for follow up visits. Tell her this is common and she should not feel badly.

c. Mother is concerned the child has continued to have recurrent ear infections. Assure her that recurrent ear infections are common in children.

d. After Mother gives information about the child's medical providers and is asked if there are any other providers to whom she has taken the child, she reports that there are. However, she claims they are not relevant since the child was seen by these other providers for either well baby visits, shots, or emergency treatment unrelated to ear infection and upper respiratory infection. You do not have to press to get the additional names and addresses.

e. Mother has moved from one section of the city to another or from one city to another since the 24 month visit. Ask for the names of all prior providers to which the child was taken. If the providers' addresses and phone numbers have already been collected at 24 months it is not necessary to get them again.

2. What if the mother has agreed to allow you to contact the medical providers, but she does not know the new providers' addresses and telephone numbers and asks to mail in the form?

Suggest that you look up the phone numbers and addresses together, if possible. (It is possible that some mothers may have difficulty looking for this kind of information.) If the mother still seems reticent or it is not possible to look up the numbers during the home visit, take the information offered and look up the numbers after the visit. Call the new medical providers for the full addresses, if necessary.

3. What if the mother asks if the medical providers gave any information at the 15 month data collection?

The interviewer should have looked up whether the child's medical providers returned the 15 month form before the 36 month visit. See form 39L-b prepared prior to the 36 month home visit - a form that should be familiar to the home visitor. She should respond either "Yes," or "No".

4. What if the mother asks if she can get some feedback on what the medical provider(s) reported at 15 months?

Tell her the medical provider(s) must be assured that the information will be kept confidential in order for them to agree to release it. Suggest that if she wants to know more about what the medical provider(s) have found, she may want to call her medical providers directly.

5. What if the mother does not have a medical provider and

asks for a referral?

Sites may want to give the mother the name of a referral source from whom she can get the name of a medical provider.

6. What if the mother wants to know more about how this information is going to be used?

Suggest that if she still has questions, she can contact the Study coordinator or Principal Investigator at your site, or ask her if she would prefer to be called by one of the study heads.

IX. DATA COLLECTION DOCUMENTATION SUMMARY

Regardless of the option chosen each site will complete the OM Data Collection Summary Sheet (39L-J). This sheet will document all data collected and/or missing for each subject. It is to be filled out as the data come in for options 1 & 2, or it is to be completed after the nurse has visited the doctors' offices for option 3.

If there are data missing on any subject due to:

1) failure to receive forms from the physician,

2) receipt of only partial data from 15-36 months but not 0-15 months,

3) receipt of forms from only some of but not all of the physicians listed by the mother,

4) Forms filled out by someone either than a physician or nurse

5) mothers or physician refusals, then these subject ID

numbers must be forwarded to the DCC so that their data are not included in the final tally. Thus, at the conclusion of data collection, one copy of the OTITIS MEDIA DATA COLLECTION - SUMMARY SHEET form (39L-J)should be sent to the DCC, one to Temple University and one kept at the site.

X. DOS AND DON'TS

1. Do try to collect all otitis media data in accordance with the mission.

2. Don't bother with heroic measures if it is apparent that you will have missing data on a particular subject. That is - if one practice in your area refuses to share the data, or if you can only get the data for 15-36 months on a given child, then the child involved here will have missing data. Try everything possible if all doctors will participate, but don't bother collecting partial data.

XI. THE CHECKLIST

To collect otitis media data sites should:

1) Appoint a Coordinator in charge of ear infections who is completely familiar with the practices and forms associated with the ear infection procedures.

2) Know our data collection mission.

3) Have the home team practice the script to the mother that appears at the home interview and read the Trouble

shooting Section.

4) Have the mother fill out the Physician Health Form.

5) Develop an option for data collection.

   a) Option 1: Otitis Media - Simultaneous Collection

   b) Option 2: Otitis Media - Simultaneous Collection with Reimbursement

   c) Option 3: Otitis Media - Post Common Protocol Collection (With Nurse or Doctor Going to Office).

6) The site coordinator in consultation with the ear infection coordinator must sign the contract and return it to the Temple site by December 1, 1993. If amendments to the chosen option are desired, they must be included in the contract.

7) The contract will be reviewed by Temple and co-signed with one copy returned to the original site and a copy sent to the DCC.

8) The site is then responsible for collecting data in the agreed upon manner.

9) All returned data is sent to the DCC.

10) The DCC is also given ID numbers of subjects who have complete (0-36 months from all doctors) rather than partial data as recorded on the OTITIS MEDIA DATA COLLECTION SUMMARY SHEET, form 39L-J.

XII. APPENDICES

A. SAMPLE LETTERS TO PHYSICIANS FORM 39L-b

Option 1: Version 1a - New Doctor Original Letter To Physicians Who Have Not Participated Or To Those Who Have Never Been Contacted.

Letter to be sent to doctors from whom information is being requested at 36 months. This letter refers to and is to be used with the short form.

Date

Name
Address
City, State Zipcode

Dear Dr.____________________________:

Your patient, Y, is part of the NICHD Study of Early Child Care. In this study, the general question we want to answer is: "How do children's early experiences in their family and in different kinds of child care contribute to their development?" One specific question we are asking is: "How do incidents of otitis media differentially affect cognitive outcomes in day care children?"

Your patient's parent has given us permission to request information from you about the episodes of otitis media in this child. We are requesting this information about otitis media from you because we believe that the information you can provide us will be far superior to any that we can collect by parental questionnaire alone.

Enclosed please find a signed consent form from your patient's parent and a short health form on which to record incidents of otitis media. We want to know the dates of this child's first and last visits with you, whether you ever recommended or performed a myringotomy on this patient, and whether you ever saw this patient for ear infections. If the answer to the last question is yes, you will be asked to provide for each episode of ear infection the date of the initial visit, the date of the last follow-up visit (if any), and whether on examination the ears were clear of fluid at the time of the last follow-up visit. A definition of what constitutes an episode of otitis media is given at the beginning of the enclosed health form.

We would appreciate it if you or your nurse would take the time to fill out our form for essential information about otitis media and return it in the enclosed envelope during the next couple of days.

If you have any further questions about the information being requested or about the study in general, please feel free to contact ______________________ or __________________________ at
(principal investigator) (study coordinator)

__________________.
(telephone number)

Thank you in advance for your cooperation.

Sincerely,

Principal Investigator

Study Coordinator

Option 1: Version 1b - Previously Contacted Doctor For Return Letters To Physicians Who Participated From 0-15 Months And Returned Forms.

Letter to be sent to doctors from whom information is being requested at 36 months. This letter refers to and is to be used with the short form.

Date

Name
Address
City, State   Zipcode

Dear Dr.__________________________:

Your patient, Y, is part of the NICHD Study of Early Child Care. In this study, the general question we want to answer is: "How do children's early experiences in their family and in different kinds of child care contribute to their development?" One specific question we are asking is: "How do incidents of otitis media differentially affect cognitive outcomes in day care children?" You may recall that we contacted your office when Y was 15 months old and you were kind enough to participate in the first phase of our research.

Now we are entering the second phase of our data collection as Y is 36 months old. Y's parent has given us permission to request information from you about the episodes of otitis media in this child. We are requesting this information about otitis media from you because we believe that the information you can provide us will be far superior to any that we can collect by parental questionnaire alone.

Enclosed please find a signed consent form from your patient's parent and a short health form on which to record incidents of otitis media. We want to know the dates of this child's first and last visits with you, whether you ever recommended or performed a myringotomy on this patient, and whether you ever saw this patient for ear infections. If the answer to the last question is yes, you will be asked to provide for each episode of ear infection the date of the initial visit, the date of the last follow-up visit (if any), and whether on examination the ears were clear of fluid at the time of the last follow-up visit. A definition of what constitutes an episode of otitis media is given at the beginning of the enclosed health form.

We would appreciate it if you or your nurse would take the time to fill out our form for essential information about otitis media and return it in the enclosed envelope during the next couple of days. Thank you again for your earlier participation in this research and for your continued support.

If you have any further questions about the information being requested or about the study in general, please feel free to contact_________________________ or _____________________________

(principal investigator) (study coordinator)

at __________________.

(telephone number)

Thank you in advance for your cooperation.

Sincerely,

Principal Investigator

Study Coordinator

Option 2: Version 2a - Doctor Reimbursement: For New Doctor For Physicians Who Will Be Reimbursed For Their Efforts.

Letter to be sent to doctors from whom information is being requested at 36 months. This letter refers to and is to be used with the short form.

Date

Name
Address
City, State   Zipcode

Dear Dr.____________________________:

Your patient, Y, is part of the NICHD Study of Early Child Care. In this study, the general question we want to answer is: "How do children's early experiences in their family and in different kinds of child care contribute to their development?" One specific question we are asking is: "How do incidents of otitis media differentially affect cognitive outcomes in day care children?"

Your patient's parent has given us permission to request information from you about the episodes of otitis media in this child. We are requesting this information about otitis media from you because we believe that the information you can provide us will be far superior to any that we can collect by parental questionnaire alone.

Enclosed please find a signed consent form from your patient's parent and a short health form on which to record incidents of otitis media. We want to know the dates of this child's first and last visits with you, whether you ever recommended or performed a myringotomy on this patient, and whether you ever saw this patient for ear infections. If the answer to the last question is yes, you will be asked to provide for each episode of ear infection the date of the initial visit, the date of the last follow-up visit (if any), and whether on examination the ears were clear of fluid at the time of the last follow-up visit. A definition of what constitutes an episode of otitis media is given at the beginning of the enclosed health form.

We would appreciate it if you or your nurse would take the time to fill out our form for essential information about otitis media and return it in the enclosed envelope during the next couple of days. Further, we will send you a small reimbursement of $______ for each returned patient form.

If you have any further questions about the information being requested or about the study in general, please feel free to contact ____________________ or ________________________ at

(principal investigator) (study coordinator)

__________________.

(telephone number)

Thank you in advance for your participation in this study.

Sincerely,

Principal Investigator

Study Coordinator

Option 2: Version 2b - Doctor Reimbursement: For Previously Seen Complaint Doctor For Physicians Who Will Be Reimbursed For Their Efforts.

Letter to be sent to doctors from whom information is being requested at 36 months. This letter refers to and is to be used with the short form.

Date

Name
Address
City, State Zipcode

Dear Dr.__________________________:

Your patient, Y, is part of the NICHD Study of Early Child Care. In this study, the general question we want to answer is: "How do children's early experiences in their family and in different kinds of child care contribute to their development?" One specific question we are asking is: "How do incidents of otitis media differentially affect cognitive outcomes in day care children?"

Your patient's parent has given us permission to request information from you about the episodes of otitis media in this child. We are requesting this information about otitis media from you because we believe that the information you can provide us will be far superior to any that we can collect by parental questionnaire alone.

Enclosed please find a signed consent form from your patient's parent and a short health form on which to record incidents of otitis media. We want to know the dates of this child's first and last visits with you, whether you ever recommended or performed a myringotomy on this patient, and whether you ever saw this patient for ear infections. If the answer to the last question is yes, you will be asked to provide for each episode of ear infection the date of the initial visit, the date of the last follow-up visit (if any), and whether on examination the ears were clear of fluid at the time of the last follow-up visit. A definition of what constitutes an episode of otitis media is given at the beginning of the enclosed health form.

We would appreciate it if you or your nurse would take the time to fill out our form for essential information about otitis media and return it in the enclosed envelope during the next couple of days. Further, we are happy to inform you that a change in our circumstances now permits us to send you a small reimbursement of $_______ for each returned patient form. Thank you again for your earlier participation in this research and for your continued support.

If you have any further questions about the information being requested or about the study in general, please feel free to contact ___________________________ or ________________________________ at
(principal investigator) (study coordinator)
___________________.
(telephone number)

Thank you in advance for your participation in this study.

Sincerely,

Principal Investigator

Study Coordinator

Option 2: Version 2c - Doctor Reimbursement: For Previously Contacted Non-Compliant Doctor For Physicians Who Will Be Reimbursed For Their Efforts.

Letter to be sent to doctors from whom information is being requested at 36 months. This letter refers to and is to be used with the short form.

Date

Name
Address
City, State   Zipcode

Dear Dr.____________________________:

Your patient, Y, is part of the NICHD Study of Early Child Care. In this study, the general question we want to answer is: "How do children's early experiences in their family and in different kinds of child care contribute to their development?" One specific question we are asking is: "How do incidents of otitis media differentially affect cognitive outcomes in day care children?"

Your patient's parent has given us permission to request information from you about the episodes of otitis media in this child. We are requesting this information about otitis media from you because we believe that the information you can provide us will be far superior to any that we can collect by parental questionnaire alone.

Enclosed please find a signed consent form from your patient's parent and a short health form on which to record incidents of otitis media. We want to know the dates of this child's first and last visits with you, whether you ever recommended or performed a myringotomy on this patient, and whether you ever saw this patient for ear infections. If the answer to the last question is yes, you will be asked to provide for each episode of ear infection the date of the initial visit, the date of the last follow-up visit (if any), and whether on examination the ears were clear of fluid at the time of the last follow-up visit. A definition of what constitutes an episode of otitis media is given at the beginning of the enclosed health form.

We understand that you were very busy and unable to complete these forms when Y was 15 months old. If you could take the time to assist us now that Y is 36 months old, it would be greatly appreciated. Please return the form in the enclosed envelope during the next couple of days. As an added incentive, we are happy to inform you that our circumstances have changed and that we can now send you a small reimbursement of $_______ for each returned patient form.

If you have any further questions about the information being requested or about the study in general, please feel free to contact

________________________ or _____________________________ at
(principal investigator) (study coordinator)

_________________.
(telephone number)

Thank you in advance for your participation in this study.

Sincerely,

Principal Investigator

Study Coordinator

Option 3: Version 3a - External Data Collector For Option 3, Version 3a In Which Trained Personnel (Doctors Or Nurses) From Sites Visit Doctors Offices.

Letter to be sent to doctors from whom information is being requested at 36 months. This letter refers to and is to be used with the short form.

Date

Name
Address
City, State   Zipcode

Dear Dr.__________________________:

Your patient(s), Y (A, B etc., if multiple patients) is part of the NICHD Study of Early Child Care. In this study, the general question we want to answer is: "How do children's early experiences in their family and in different kinds of child care contribute to their development?" One specific question we are asking is: "How do incidents of otitis media differentially affect cognitive outcomes in day care children?"

Your patient's parent has given us permission to request information from you about the episodes of otitis media in this child. We are requesting this information about otitis media from your office because we believe that the records that you can provide us with will be superior to any that we can collect by parental questionnaire alone.

With your permission, we would like to send a trained nurse to your office to record the otitis media records from Y (A, B, etc., if multiple patients). Enclosed, you will see a signed consent form from your patient's parent. Someone from our office will phone you in the next couple of days so that we can schedule a mutually convenient time for the nurse to visit your practice.

If you have any further questions about the information being requested or about the study in general, please feel free to contact
__________________________ or ______________________________ at
(principal investigator)   (study coordinator)
____________________.
(telephone number)

Thank you in advance for your cooperation.

Sincerely,

Principal Investigator

Study Coordinator

Option 3: Version 3b - External Data Collector For Option 3, Version 3b In Which Trained Personnel (Doctors Or Nurses) From Sites Visit Doctors Offices. (Previously Seen Compliant Doctors)

Letter to be sent to doctors from whom information is being requested at 36 months. This letter refers to and is to be used with the short form.

Date

Name
Address
City, State   Zipcode

Dear Dr._________________________:

Your patient(s), Y, (A, B etc., if multiple patients) is part of the NICHD Study of Early Child Care. In this study, the general question we want to answer is: "How do children's early experiences in their family and in different kinds of child care contribute to their development?" One specific question we are asking is: "How do incidents of otitis media differentially affect cognitive outcomes in day care children?"

Your patient's parent has given us permission to request information from you about the episodes of otitis media in this child. We are requesting this information about otitis media from your office because we believe that the records that you can provide us with will be superior to any that we can collect by parental questionnaire alone.

We are happy to inform you that we have altered our data collection procedure to save you time. Therefore, with your permission, we would like to send a trained nurse to your office to record the otitis media records from Y (A, B, etc., if multiple patients). Enclosed, you will see a signed consent form from your patient's parent. Someone from our office will phone you in the next couple of days so that we can schedule a mutually convenient time for the nurse to visit your practice.

Thank you for your earlier participation in this research and for your continued support.

If you have any further questions about the new procedure or about the study in general, please feel free to contact

_________________________ or ______________________________ at
(principal investigator) (study coordinator)

__________________.
(telephone number)

Thank you in advance for your participation in this study.

Sincerely,

Principal Investigator

Study Coordinator

Option 3: Version 3c - External Data Collector For Option 3, Version 3c In Which Trained Personnel (Doctors Or Nurses) From Sites Visit Doctors Offices. (Previously Contacted Non-Compliant Doctors)

Letter to be sent to doctors from whom information is being requested at 36 months. This letter refers to and is to be used with the short form.

Date

Name
Address
City, State Zipcode

Dear Dr.____________________________:

Your patient(s), Y, (A, B etc., if multiple patients) is part of the NICHD Study of Early Child Care. In this study, the general question we want to answer is: "How do children's early experiences in their family and in different kinds of child care contribute to their development?" One specific question we are asking is: "How do incidents of otitis media differentially affect cognitive outcomes in day care children?"

Your patient's parent has given us permission to request information from you about the episodes of otitis media in this child. We are requesting this information about otitis media from your office because we believe that the records that you can provide us with will be superior to any that we can collect by parental questionnaire alone.

We understand that you are very busy and were unable to complete these forms when Y was 15 months old. However, we have changed our procedures to relieve you of the work involved in the data collection process. We hope that the following procedure will be more to your liking and that you will be able to assist us in the collection of the 36 month data on Y.

With your permission, we would like to send a trained nurse to your office to record the otitis media records from Y (A, B, etc., if multiple patients). Enclosed, you will see a signed consent form from your patient's parent. Someone from our office will phone you in the next couple of days so that we can schedule a mutually convenient time for the nurse to visit your practice.

If you have any further questions about this new procedure or about the study in general, please feel free to contact ____________________
(principal investigator)

or ____________________ at ____________________.
(study coordinator) (telephone number)

Thank you in advance for your cooperation.

Sincerely,

Principal Investigator

Study Coordinator

B. Physician Contact Form 39L-a

C. Physician Health Form - Short 39L-c

PHYSICIAN HEALTH FORM: NICHD STUDY OF EARLY CHILD CARE

Child's name ____

Subject number: ____

Today's date: ____

Physician's name: ____

Person completing form: ______________________________________

______________________________________(name)

__________________________________(position)

Phone number: ____

Thank you for taking some time to complete this form. We are interested in ear infections that were diagnosed in the office or clinic. Please give the information requested on this child in chronological order starting from the following date: ____________

We are defining an episode of otitis media (or effusion) as one which starts at the date of the first examination (for that episode) and which may last as long as 30 days. Thus, if the child is diagnosed as having ear infection and it continues for 30 days or less, that is to be counted as one episode.

If, on the other hand, the child continues to have fluid in the ear for more than a month, the next visit for otitis media is to be counted as a new episode.

Finally, if the child's ear has been clear of fluid for ANY amount of time (two days, one week, two week, etc.), any new diagnosis of infection or fluid following this period of being clear of fluid is to be considered a new episode.

PHYSICIAN HEALTH FORM

Please provide the following information:

1. When did this child first become a patient

   ____
   month day year

2. When was this patient last seen?

   ____
   month day year

3. Has anyone (or another medical provider you know of) recommended that tubes be implanted in this child's ears?

   (Circle one) Yes
   No
   Don't know

4. Have tubes ever been implanted in this child's ears?

   (Circle one) Yes
   No
   Don't know

5. If yes, when?

   ____
   month day year

6. Have you seen this child for ear infections since the date recorded on the cover sheet of this form?

   (Circle one) Yes (Continue)
   No (STOP HERE)

PHYSICIAN HEALTH FORM

Ear Infection Episode Date of initial visit Mo Day Yr	Was there a follow-up vist for this episode*? Y/N	If Yes, date(s) of follow-up visit(s) for this episode* Mo Day Yr	If Yes, was there fluid in the ear at time of last follow-up visit for this episode*? Y/N
1.		1. 2.	
2.		1. 2.	
3.		1. 2.	
4.		1. 2.	
5.		1. 2.	
6.		1. 2.	
7.		1. 2.	
8.		1. 2.	
9.		1. 2.	
10.		1. 2.	
11.		1. 2.	
12.		1. 2.	
13.		1. 2.	
14.		1. 2.	

1001

1002

* 'this episode' is defined as within 30 days of the initial visit. If there are continuing symptoms, the next follow-up visit after 30 days should be counted as the initial visit of a new episode.

D. OTITIS MEDIA - CONTRACT

We at the ______________________________________ site agree to collect the otitis media data by adhering to *Option #______.

Any proposed amendments to this option are listed below.

AMENDMENTS

____

____

____

____

____

____

____
Representative from site

____
Dr. Kathy Hirsh-Pasek
Temple Site

* Option 1: Simultaneous Collection
Option 2: Simultaneous Collection with Reimbursement
Option 3: Post Common Protocol Collection by Trained Personnel

ADDENDUM TO CHAPTER 28.5
PROCEDURES FOR COLLECTING EAR INFECTION DATA

Please note that the previous addendum (01/24/94) to this manual is being replaced with this current addendum.

I. Ear Infection Form (15L) Clarifications

1. On page 2 of Form 15L, the initial date of the ear infection is entered. Next, there is a yes/no question as to whether there was a follow-up visit for this episode. If this question is answered "yes", then the next item (Question B2) asks for the date of the last follow-up visit for this episode. The date given for this question should be the very last follow-up visit for this episode within the thirty day definition. Remember that a follow-up visit that occurs after thirty days of the initial visit constitutes filling in a new episode of otitis media.

2. Question B3 asks if there was continued fluid in the ear. If the answer to B3 is "yes" (there was continued fluid in the ear at the last follow-up visit) then skip Question B4, which asks for the date that the ears were clear of fluid. Using the thirty day definition for this form, this question (B4) can only be answered if Question B3 is answered "No" (No, there was not continued fluid in the ear at the last follow-up visit), in which case the date of the last follow-up visit (obtained in Question B2) would be the answer.

II. Manual Changes

1. Page 14: Insert at the end of the first paragraph:

If more than one doctor is listed on the Physician Contact Form (39L-a) then make certain that the names are transferred to the Ear Infection Follow-Up Form (Forms 39L-b1, b2, or b3) in the same order. This will establish the labeling of those doctors as "doctor #1" or "doctor #2".

2. Page 16: Insert on line 2 prior to "Also, ...":

If data are returned from more than one doctor for an individual subject, this must be indicated on both the short (Physician Health Form, 39L-c) and scantron (15L) forms. Refer to the Ear Infection Follow-Up Form (Form 39L-b1, b2, or b3) and label the doctors according to the listing on this form. Write the appropriate number e.g., "doctor #1" or "doctor #2", in the upper right-hand corner of both the short (Physician Health Form, 39L-c) and the scantron (15L) forms.

ADDENDUM TO CHAPTER 29.1
OPERATIONS MANUAL 36 MONTH LAB VISIT

I. Families Who Cannot Come To The Lab

Some families are willing to participate in the study but cannot come to the lab. This occurs for people who have moved a long distance from the site or, as in one case, a mother who cannot travel. If families are unable to come to the laboratory, but are willing to have a second home visit, then the following parts of the lab visit may be administered in the home. The data should be flagged, however, to indicate that the data was collected in the home.

24 month Lab Visit:

* Solitary Play (if a quiet room is available)
* Clean Up
* Bayley
* Three Boxes
* Interview Sections I, II, and III
* Child Behavior Checklist
* Adaptive Social Behavior Inventory

36 Month Lab Visit:

* Solitary Play (if quiet room is available)
* Clean-Up
* Three Boxes
* Child Behavior Checklist
* Adaptive Social Behavior Inventory
* Peabody Picture Vocabulary Test
* TV Interview

Please note that these procedures should not be added to the regular home visit. They should be conducted in a separate home visit.

II. Clarification of the Lab Tape Mailing Procedures

There should be only one lab session per tape for Solitary Play, Separation & Reunion and Snack which is sent to Seattle. Use both mailing labels on the spine of the tape and the box to indicate if both Solitary Play and Separation & Reunion are recorded on the tape, or if a procedure if missing. Only the procedure(s) that is included on the tape is indicated on the tape label. Use both shipping lists - one for Solitary Play and one for

Separation & Reunion. The Seattle site has two coding teams who will be tracking the data received, etc.

For the tapes that are sent to Margaret Owen in Texas, there should be four sessions of Self-Control on one tape, four sessions of Mother-Child Interaction on one tape, and four sessions of Clean-Up on another tape. Please use the appropriate tape labels and transmittal sheets.

CHAPTER 29

Section 1

OPERATIONS MANUAL THIRTY-SIX-MONTH LABORATORY VISIT

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CHAPTER 29

Section 1

OPERATIONS MANUAL 36-MONTH LABORATORY VISIT

I. OVERVIEW OF THIS MANUAL

The laboratory visit at 36 months consists of a series of procedures designed to assess children's cognitive and social-emotional development and some tests and questionnaires to be administered to the mother. The visit takes approximately 2 1/2 hours.

We have attempted to consider as many questions and contingencies as possible. However, situations that we have not anticipated may arise during the course of data collection. When you are presented with a situation that is not covered in the manual, capture it as accurately as possible (i.e., write down the details of the situation), then contact your PI, Site Coordinator or Bonnie Knoke at the Data Coordinating Center. They will confer with the relevant individuals and give you a coding decision, an interpretational decision, or whatever is needed. These responses will be distributed to all sites by e-mail. Each of these new decisions will then be recorded in an addendum to this manual that will also be distributed to all sites.

II. GENERAL CONSIDERATIONS FOR THE 36-MONTH LAB VISIT

A. Personnel to Conduct the Visits

Two people are necessary to conduct the lab visit. One person, the Visit Coordinator, is responsible for coordinating the visit. The second person will operate the camera and can conduct the assessments administered to the mother. If siblings are present, a third person should serve as a childminder.

All the members of the laboratory staff should be friendly, relaxed, and professional when interacting with the visiting family. They should be thoroughly familiar with the laboratory protocol in order to be flexible when problems arise. Staff members should become familiar with 36-month-old children (see Section II.F, About thirty-six-month-olds). Finally, if any staff member is contagious with any illness, they should find a trained substitute to conduct their portions of the visit. The staff should wear casual, yet professional clothes.

B. Parent or Caregiver to be Interviewed

The mother will usually accompany the child to the laboratory visit. If, however, the child is permanently in the care of someone other than the mother (e.g., father, grandparent, stepparent, foster parent), this person should accompany the child. In this instance, "permanent" should be defined as follows: the child has been in the primary care of someone other than the mother and the mother has not been living with the child for at least 3 months prior to the visit. This person will be the accompanying adult even if the family expects the mother to resume care of the child (e.g., she has been hospitalized). If the mother has been living away from the child for less than 3 months, but the current caregiver has been caring for the child for at least 3 months (e.g., father) do the visit with that caregiver. If the current caregiver has been caring for the child less than 3 months, delay the visit until a) the caregiver has been with the child for 3 months or b) the mother has returned and cared for the child for at least 1 month. If the visit cannot be conducted within the window or exception period (see below), then there will be missing data for this subject.

C. Window for Data Collection

Phone calls to schedule the lab visit (along with the home and child care visits) begin at 35 months. To be within the desired window, the lab visit may occur any time from the child's 36-month birthday up to the 38-month birthday. The home visit will normally precede the lab visit. The order of the lab and child care visits can vary. If necessary, visits can be conducted up to but not including 41 months 0 days. All visits conducted on or after 38 months 0 days will be "flagged" as an exception on the data forms and must be approved by a principal investigator. An EXCEPTION PERIOD DATA COLLECTION APPROVAL form should be sent to the DCC along with any data collected on or after 38 months 0 days. See Chapter 13 for details on filling out this form.

Lab visits for more than one child may be scheduled on a single day, but a 3-1/2 hour block of time should be allotted for each visit. Families are often late or early. Allow sufficient time when scheduling families to avoid families having to wait for their visit to begin because another family is being observed.

Visits can be scheduled at any time of day that the mother is confident will be a time when the child is fresh and alert. There is no required time for Mother and child to be together before the visit, but they should not have had any unusual overnight separations in the previous week.

D. Materials and Facilities

1. Observation Rooms

One room is needed for the 36-month lab visit. This room should have a one-way mirror so that videotaping can be done from behind the glass. It should be equipped with two adult-size chairs. A child-size table and two child-size chairs will be needed part way through the visit. Later in the visit an adult-sized table, end table and throw rug will also be needed. Posted on the wall should be a chart showing "Activities for the Day."

(see Section 2). Aside from this chart, there should be no decorative posters in the room.

2. The details of the materials needed for each part of the visit are given in the submanuals for Solitary Play,Separation and Reunion, Snack, Reynell Developmental Language Scales, Self-Control, Three Boxes, Peabody Picture Vocabulary Test-Revised, Television Viewing Interview, Adaptive Behavior Scale, Child Behavior Checklist, and Growth Measures. They are also listed in appendix 29.1.A.

E. Health and Safety Concerns

Listed below are a few health and safety related issues that each site needs to consider as they make their final adjustments on their lab set-ups.

1. Be sure all electrical outlets are covered. In addition to covering the outlets in the experimental rooms, you may want to cover the outlets that are located in hallways which connect the playrooms and any rooms where visiting siblings will be likely to venture.

2. All sites need to make sure that their toy washing facility is independent of the diaper changing area. The Box of baby wipes provided for the mother during snack should not be the same box used for diaper changes. If at all possible, toys and dishes should be washed in a kitchen where hot soapy water is available

for disinfecting the toys. Toys and dishes must be rinsed and then dried after washing.

3. Toys should be washed after a visit if the child has put them in her/his mouth or appears to have a contagious illness, (e.g., runny nose, coughing). You are not required to wash toys after every visit, but if you have any doubts about their cleanliness, do wash them.

4. Although most 3-year-olds will be out of diapers, there should be a diaper changing area. The diaper changing area should include a diaper changing table, disposable diapers, baby wipes, and detergent for cleaning the diaper changing table. Do not use an absorbent pad on the changing table. After washing and rinsing the changing table, it should be wiped dry with a disposable towel.

5. Soiled diapers must be removed from the diaper changing area after each visit. Soiled diapers should be disposed of in a plastic bag that can be removed from the diaper changing area by the visit coordinator after the visit has been completed. Hands should be washed after removing the diaper pail.

6. Each site should have access to a vacuum cleaner for cleaning up the floor around the snack area after each visit. This will be especially important when there are multiple lab visits scheduled on one day.

7. After consultation with faculty in pediatrics and nursing, four bits of advice:

* Don't use Sidex (a very strong disinfectant)

* Wash your hands

* Rinse the toys and tables

* Dry everything after washing with disposable towels.

F. About thirty-six-month-olds

It is important for the Research Assistants to be comfortable with 36-month-olds and knowledgeable about their ways. Thirty-six-month olds are not like the infants and toddlers seen during the earlier home visits. Most are quite mobile and have surprisingly good communication skills. Most have also begun to demonstrate some self care routines. They no longer need parents to do everything for them, but they are still quite dependent on adults for managing many of their affairs. It is not uncommon for three-year olds to assert their independence and to make choices (sometimes quite stubbornly) about things they like and dislike. They are alternately full of wonder and full of themselves. Throughout this manual, we will try to refer to a three-year-old as a child. Three-year-olds generally do not like to be called 'babies'.

Reading about three-year-olds is a good idea. Site Directors often can recommend good reading material; there are several developmental textbooks that do an excellent job. See Chapter 28.1, Section II.B.

It is also helpful to review the place of the 36-month visit within the context of the full study. Families' lives are changing. Many more mothers will be back at work. The children are quite mobile, can often communicate quite well, and are in the process of exploring the world on their own, testing limits, and in some cases, patience. The youngsters are interacting more and more with others, and they will be more curious about you and your equipment than ever before. The children may be involved in numerous exchanges with siblings. Many will have at least one younger sibling by now.

III. ORGANIZATION OF THE VISIT

A. Overview of Procedures

Listed below is a brief summary of the sequence of the 36-month lab visit.

Welcome and initial instructions (Conducted in the parking lot, hallway and/or office)

Bathroom break, if needed

CHILD	MOTHER
Solitary play	Explanation of session
Clean-up (compliance)	Clean-up with child
Bathroom break	Bathroom break
Plays in room	Remains in room Leaves room Returns Leaves room Returns
Snack	Snack with child
Bathroom break, if needed	Break if needed
Reynell Language Scale	Completes CBCL
Self-control with attractive toy	Completes ASBI
Three Boxes interaction	Three Boxes interaction
Sites Specific or Informal Play	PPVT and TV interview
Growth Measures	Assisting with the growth measures
Site Specific or Informal Play	Debriefing

During the first part of the visit, the child engages in Solitary Play while the Visit Coordinator describes the visit to the mother. At an appropriate point, the mother is handed a card which describes the Separation and Reunion procedure. At the end of solitary play, the mother is asked to have the child place the toys in a bin, i.e., clean up the toys, while the Visit Coordinator leaves the room to get the next set of materials. When the Visit Coordinator returns she announces that at this point everyone takes a "bathroom break." Tell mother where the bathroom is and ask her to walk the child there to "try." Our aim is to avoid having children needing to go to the bathroom during "Comings and Goings" (the Separation and Reunion procedure). If the child just had a bathroom visit prior to or during Solitary Play, then it's not necessary to make the walk again; ask anyway, however. When Mother and Child return from the bathroom break, the Visit Coordinator shows them into the room handing mother a reminder card to leave at the knock. After 3 minutes, the Visit Coordinator knocks on the window to signal the mother it is time to leave. It is very important that the departure of the mother take place in the playroom, on videotape. How the mother leaves, and what she says to her child, is up to the mother. There are two separations and reunions. Three minutes after the second reunion the Visit Coordinator brings in the snack. Then there is an optional bathroom break and the room is rearranged for the Reynell. The Reynell and Self Control procedures are administered while the mother works on questionnaires. At the end of SELF CONTROL, the examiner brings in the three Boxes and gives the mother her instructions. The 3

Boxes task is given to the mother and child together. It is a good idea to offer mother and child some refreshments at this point. Then the PPVT and TV interview are administered to the mother while the child plays or participates in site specific tasks. At the end of the visit, the child's weight and height are measured and the mother completes any procedures not completed earlier, including questions 1-6, of the Lab Visit Monitoring Form (Form 38I).

B. Logistics

What follows is one pattern by which two people can conduct the visit. The exact role of each will depend on the physical set-up of the laboratory; however, there are some general principles.

1. One experimenter works primarily with the child, so s/he becomes familiar to the child. The second experimenter operates the videotape equipment. Either can administer tests and questionnaires to the mother. A third person is needed to babysit if extra children are present.
2. Someone must be watching the child when the child is left alone. Someone (preferably the Visit Coordinator with whom the child is familiar) needs to be immediately outside the door to deal with the child if the child tries to leave the room. The mother should be in the observation booth when the child is left

alone so she can go into the room quickly if the child becomes upset.

Visit Coordinator A	**Visit Coordinator B**
1. Introduces solitary play and initial explanation to Mom. During solitary play gives mother instruction card for Comings and Goings.	1. Operates camera for solitary play.
2. Hands Mom Clean-up instructions, basket and leaves the room.	2. Continues to operate camera.
3. Returns to tell Mother and Child about bathroom break. Waits in room for family's return.	3. Rearranges room for Separation/Reunion.
4. When Mother and child return, hands Mom reminder card about the upcoming knock and leaves. In observation room, waits 3 minutes and knocks on window.	4. Operates camera
5. Waits in observation room for Mom to enter, then stands by door in case child goes to door.	5. Operates camera. Cues Mom to return after 3 minutes, or after 30 seconds if child is distressed.
6. Goes back into observation room to knock on window for second separation	6. Quickly passes hand in front of camera lens to signal mother's return
7. Waits in observation room for Mom to enter, then stands by door in case child goes to door.	7. Operates camera. Cues Mom to return in 5 minutes or after 30 seconds if child gets distressed
8. Waits 3 minutes then brings Snack	8. Quickly passes hand in front of camera lens to signal mother's return to room. Continues to operate camera for snack

9. Informs mother and child of optional bathroom break. While they are out, sets up Reynell, sets out mother's questionnaires.	9. Operates camera if videotaping is wanted
10. Tells Mother CBCL instructions. Administers Reynell.	10.
11. Tells mother ASBI instructions. Administers Self Control	11. Operates camera
12. Rearranges room for Three Boxes, instructs mother and leaves	12. Operates camera
13. Offers refreshments to mother and child.	13.
14. Conducts site-specific activities or plays with child.	14. Administers PPVT and TV interview to mother
15. Weighs and measures child	

*Note: Either Visit Coordinator A or Visit Coordinator B can administer the PPVT and TV Interview.

C. Confirm with the Mother the Evening Before the Visit

A staff member should call the mother the evening before the visit to confirm the time for the visit and make sure the mother is coming. At this time the Visit Coordinator should make certain that the child is not ill, and has had no unusual separations from Mother in the last week. If the mother cannot keep the appointment, the caller should gather the information necessary for rescheduling (Form 14F - keep at sites).

During the call, check on whether there are other children who need care during the visit. Remind the mother that we prefer to have her come without other people. Remind her that we can provide her baby sitting money so that she can leave her other children at home. If she says she needs to bring other children, explain that they will need to stay in another room for part of the time and that they will be supervised. Then arrange to have a third staff member and a space to care for them. If the mother says that her husband/partner or a friend wishes to come, explain that they will need to observe from the observation room because the child may be distracted by their presence. Finally, remind the mother that we will pay her and reimburse her for mileage or arrange transportation.

A suggested script to follow is:

"Hi, I'm __CALLER NAME__ from the NICHD Study of Early Child Care. I'm calling to confirm your visit to our playroom that is scheduled for tomorrow at __(TIME)__. We have found that the visit to our playroom works best when children are in good health and haven't had any big changes in their routine during the week before their appointment. Is CHILD currently ill? (COLDS ARE GENERALLY UNAVOIDABLE. WE ARE CONCERNED ABOUT FEVERS AND MORE SEVERE SYMPTOMS.) Has CHILD had any recent major changes in the amount of time he/she has had with you?"

If the child has a fever or severe symptoms or there has been an unusual overnight separation from the mother in the past week, then reschedule the visit for at least one week later. If the child has a slight cold, go ahead with the visit. If there have been no illnesses or unusual separations, then proceed:

> *"We look forward to seeing you tomorrow at TIME. Did you receive the instructions for getting to the playroom? Did you receive your parking permit? Will you be needing money to pay for a babysitter for your other children (IF APPROPRIATE)?"* HANDLE ANY OTHER LOGISTICAL ARRANGEMENTS AS NECESSARY.

If mothers ask questions about whether they will be separated from child during visit, say that a "Comings and Goings" episode will occur after mother and child have been in the playroom for about 20 minutes. It is important to communicate that the mother should not coach the child ahead of time about the details for what is going to happen in the playroom. Tailor the following response to the mother's particular concern.

This is a briefer version of "Comings and Goings" than at 15 months.

> *"The Comings and Goings episode tells us about variations in the early development of self-reliance. We want to see how CHILD behaves when you are nearby but not in the same room. Because self-reliance is one of the areas in which we are interested, we ask you not to tell CHILD ahead of time that you and CHILD will be briefly separated for part of the playroom visit. We prefer that you simply explain*

that you and CHILD will be going to the playroom at (SITE), as you did when CHILD was younger, and that there will be lots of different things to see and do there."

D. Preparations on the Day of the Visit

The visit coordinator is responsible for assuring that the following preparations are complete:

1. All toys are clean
2. Toys and testing materials are in the appropriate places.
3. A second person is assigned to help conduct the visit.
4. Transportation is arranged for the mother and child, if necessary.
5. Free parking is arranged for the family, if necessary
6. Snack materials are prepared.
7. Video equipment is set up and checked.
8. The scale is checked to be sure that it has been calibrated within the last week. It must be zero-balanced before each time the child is weighed.
9. A childminder is available if siblings are to be present.

One hour preparation time is recommended in case there is a video malfunction to correct.

E. Family's Arrival

If necessary, the Visit Coordinator should meet the family in the parking lot, at the door of the building, at the elevator, etc. Care should be taken that the family does not become lost or have difficulty parking.

When the mother and child arrive, offer a friendly greeting, asking how everything is going, etc. For example,

> *"Hello, Mrs. SURNAME, I'm VISIT COORDINATOR'S NAME. It's nice to see you again (if previously seen). I appreciate you bringing CHILD in to our playroom today. How has everything been going for you and CHILD?"*

Be sure to notice and comment on something positive about the child to the mother. Not saying anything is sometimes taken as a slight. Saying something honestly nice is easy to do about most 36-month-olds. Be careful not to overdo it or to say anything judgmental that could be taken as a negative -- even an innocent comment can stay on the mother's mind for a long time.

Say hello to the child, but do not push him/her to respond to you. Wait for the child to warm up to you. Three-year-olds generally do not exhibit the kind of "stranger anxiety" associated with children closer to one year of age. However, this does not mean that some will not be wary or intimidated by your presence. Some are simply shy. When you feel the child is warming up to you, speak to the child or respond to the child's overture in a gentle way. Usually it is helpful to speak to the child at the child's eye level. For this you may need to get down on the floor. Visitors may find it helpful to find 36-month-olds that they can spend time around in order to become familiar with children this age.

The initial greeting should take place in the hallway or parking lot. After the greeting, the mother's and child's things (stroller, coats, etc., but not the mother's purse) should be stored in an office or room not being used for the procedures.

Some children will come to the play session with some kind of security object (e.g., pacifier, blanket, doll). Ideally we would like the child to leave such objects in the storage area, but not at the cost of the child being uncomfortable. Therefore, ask the mother to suggest that the child leave the object in question, but let her know that she should not insist if the child seriously protests. Be ready to direct the mother not to bother if she seems to be too assertive in taking something away from the child. You do not want her to upset the child. Once these materials have been stored, ask the mother to take the child to the bathroom if needed and appropriate. Then, go to the Playroom and begin the SOLITARY PLAY instructions, (see Section 24.2).

F. Expressing Appreciation

Be sure to emphasize at several points during the visit the importance of the family's contribution to the research, how worthwhile and important the research is, and how much the family's time is appreciated. This is often a good thing to do when the mother and child arrive and when they leave.

G. Handling the Presence of the Father or Other Children

Because some mothers may come to the laboratory with their husband/partner and/or other children, sites should have procedures to accommodate other family members during the lab visits. Sites should have a room available in which family members may wait. The room should be equipped with toys and something for the father to read. Sites should provide a person to supervise the siblings of the study child if the father is not present. Adult family members, if they are quiet, may observe the visit from the observation room. Under no circumstances can family members be present in the playroom.

H. Ending the Visit

1. Completing questionnaires not completed in the home visit (if necessary)

If the home visit has already occurred and the mother did not complete all questionnaires, she should be asked to do so. Keep the child occupied during this time so that the mother can concentrate on the questionnaires.

2. Completing the Laboratory Visit Monitoring Form (Form 38I)

At the end of the lab visit the visit coordinator should ask the mother questions 1-6 on the form.

The questions do not need to be asked using the exact wording on the form.

All mothers should be asked questions 1, 2, 5, and 6. If the mother reports that it has been a typical day in response to question 2, then do not ask questions 3 and 4.

For question 5, "Number of hours since child was picked up at child care?", fill in the number of hours since the child was picked up from care on the day of the lab visit. If the child was picked up from care the previous day or earlier in the week then fill in NA (Not Applicable). Do not ask this question if the child is not in child care.

For question 6, if the mother answers yes then ask the second half of this question. Code her response using one or more of the choices. Do not read her the choices.

For question 7 and 8, the visit coordinator should complete these questions based on his /her observations during the visit and on comments the mother may have made during the visit.

Items 9 through 18 should be completed by the visit coordinator after the family has left. These items will provide the site and the DCC with a record of which procedures were successfully completed and the reason for failure to successfully complete a procedure. For each item, indicate whether the procedure was successfully completed. If the procedure was not successfully completed then indicate why the procedure was terminated or unsuccessful. The visit coordinator should choose the reason for failure to complete a procedure successfully.

If necessary, the visit coordinator should reschedule the procedure within the window (including the exception period). A lab Monitoring Form should be completed for each subsequent lab visit and sent to the DCC.

The following are the criteria for the successful completion of the measure:

Solitary Play - The Solitary Play procedure is successfully completed if ten minutes of video tape are obtained from the time the child engages with a toy. If the procedure is not successfully completed, then the procedure must be repeated in the lab as soon as possible.

Separation/Reunion - Sue Spieker will judge whether the Separation/Reunion is successfully completed. If all the episodes were not completed during a visit, then send the tape to Sue Spieker immediately. Include a note explaining the problem and that the tape needs to be coded as soon as possible. Seattle will then notify the site as to whether the Separation/Reunion was successfully completed or whether the procedure must be repeated.

A minimum of 10 minutes of taping is needed for codeable data. If the procedure is not successfully completed, then the Three Boxes procedure should be rescheduled in the lab as soon as possible.

Height and Weight - The Height and Weight procedure is successfully completed if two measurements of both height and weight are obtained. If the procedure is not successfully completed then repeat the procedure if there is a lab revisit scheduled to complete one of the other procedures. Do not schedule a second lab visit to collect only the Height and Weight procedure.

3. Debriefing

At the end of the visit, the mother should be "debriefed." Ask her if she has any comments or questions about the visit she would like to share with us.

4. Paying the mother

Thank the mother for all her time and help. Reiterate how important the study is and how we value her time and help. Pay her $35.00, or make arrangements to pay her. If the child measures are not completed then a second visit should be scheduled. Specifically, a second visit should be scheduled if any of the following are not complete: Solitary Play, Separation/Reunion, the Reynell, 3 Boxes, maternal PPVT. If a lab visit cannot be scheduled, these procedures can be conducted in a home visit. The television viewing interview can be completed over the phone or at a home visit, if necessary. If any questionnaires are incomplete, they can be administered at home, or over the telephone, or the mother can take them home and return them by mail. Be sure to give her a stamped return envelope and to follow-up to be sure they are returned. The mother should be paid when all necessary procedures are completed.

5. Reimburse the mother for transportation costs

Reimburse or make arrangements to reimburse the mother for the mileage to and from her home and the laboratory, or other transportation costs. Use the rate and procedures determined at your site. If possible, prior to the lab visit, determine the mileage to and from the mother's home and the laboratory by using the mileage obtained from the home visit form. If possible, reimburse the mother for transportation costs at the end of the laboratory visit.

6. Preparing for the next contact

Leave the mother a business card or some small information card with your name on it that she can file or "put on the refrigerator." If the home visit is scheduled, be sure to have the date and time of the home visit on the card. If the home visit is to be rescheduled, cross out the original date on the card. Say, *"We'll be in touch with you, but if anything changes for you or if you want to contact us, please call. Our number, and my name, is on this card."*

If the mother has already had her home visit follow the procedures for Recruitment for Phase II in manual Chapter 30.

7. Departure

Leave the mother with a good feeling about the visit. As she leaves, give the mother positive feedback along the lines of "You've really been helpful to us." "I've enjoyed meeting you, I'll look forward to seeing you again." "It was a pleasure seeing CHILD."

IV. PROCEDURES FOR VIDEOTAPING VISIT

Much of the child assessment in the 36-month visit will be recorded on videotape. Therefore, it is essential that good quality videotapes be collected. One staff member will be assigned to be the camera operator.

A. Taping Procedures

Start the clock that is recorded on the screen from the moment that the child walks into the room at the beginning of Solitary Play. Let the clock run continuously, even through "bathroom breaks" until the end of the lab session. This instruction is given with the expectation that sites can keep the "clock" running on their cameras while not actually recording, because the Reynell is not recorded. Experiment with the equipment you have to determine if this is possible. If it is not, please discuss your situation with Susan Spieker.

Taping occurs in two time blocks: (1) The first block begins at the onset of Solitary Play and continues until the end of the Snack. (The Reynell can be either audiotaped or videotaped for transcription of language. For pilot and certification subjects it should be video-taped.) (2) The second block starts at the beginning of the Self-Control procedure and ends with the conclusion of Three Boxes. Allow the tape and timer to run even if child leaves the room to go to the bathroom or for a break. If the child leaves in the middle of a procedure, note the time she/he left and returned so you will know when that task should be terminated. The specific instructions for taping each procedure are given below in IV.C. The following general instructions apply to all filming done during the laboratory visit.

1. Approximately one hour before the family is due to arrive, the camera operator should insert the videotapes and check to be sure all recording equipment is working properly.

2. At the beginning and end of the visit, record (both visually and audibly) the subject's number on the tapes. Use a board that says "begin subject #920001" and have someone read this message at the same time. After the family has left, follow a similar procedure to indicate the end of the tapes, "end subject 920001."

3. Family and staff who are observing any part of the procedures from behind the one way glass must not talk during the visit. It is important not to distract subjects in the playroom and talking can be heard through the observation window. If it is necessary to communicate, soft whispers must suffice.

4. Staff who are filming procedures from behind one way glass and all persons standing near the one-way mirror should wear dark-colored clothing. Otherwise, the reflection of light colored clothing will be captured by the videocamera and reduce picture quality. Lights in the observation room should be turned off or turned very low during filming because video cameras catch the reflection of the light against the window.

5. Staff should avoid laughing or making any comments about the child, the mother, or the family, especially if any family members are present. Even seemingly innocuous remarks can be

offensive, making people feel as though the participants are being treated as guinea pigs.

6. After the visit is completed, the camera person should check to make sure that the videotapes are codeable.

B. Copying, Labeling, and Sending the Tape

1. Copying the Videotape. Each procedure will be videotaped simultaneously on two tapes, using a splitter cord that allows the signal from the camera to be transmitted to two VCRs simultaneously. Of the two original tapes, one is the site copy. It has all the procedures. The second original contains solitary play, clean-up, Separation and Reunions, and snack (Tape 2). At the end of the snack, Tape 2 should be removed, and a tape devoted to self-control (tape 3) should be inserted in the tape recorder. Up to four Self-Control segments can be put on one tape. After taping self-control, tape 3 should be removed and a separate tape devoted to mother-child interactions (tape 4) should be inserted. Again, up to 4 mother-child segments may be recorded on a single tape. An additional tape, containing Clean-Up (tape 5) will be will be dubbed after the session. Put up to four sessions on each tape. Send Tape 2 to Seattle and Tapes 3, 4, 5, to Dallas for coding. In addition, the Solitary Play, Clean-Up, and Three Boxes portions of the tape may be copied onto the tape that will be given to the family at the end of the study.

2. Labeling the Tape

The videotapes should be labeled using labels provided by the DCC. The date of the visit and the VC ID number should be written in the space provided on the label. The labels should be placed on the outside spine of the tape and the tape box. Do not include any other identifying information on the box or the tape. Use the center of the cassette to note any unusual circumstances.

3. Where to Send the Tapes. Tape 2 should be sent by regular mail for coding to the following address:

Susan Spieker
University of Washington
CD MRC, WJ-10
Seattle, WA 98195

Tapes 3, 4, and 5 should be sent to:

Margaret Owen
Timberlawn Research Foundation
P.O. Box 270789
2750 Grove Hill
Dallas, TX 75227

C. Specific Instructions for Different Tasks

1. Solitary Play

Begin the clock just before the child enters the play room. Leave the clock running continuously through the rest of the lab session, even if the child takes a "bathroom break." The camera should be zoomed in as closely as possible while keeping child's face and body on the screen. It is important to see what the child is doing with the toys and to be able to see the child's face.

2. Clean-up

Both child and mother will be coded during this episode. Therefore, try to keep both on screen. If that is not possible, focus on the child with an occasional scan to the mother.

3. Separation and Reunion Episodes

Context is very important in coding the reunion, but so are facial expressions. Keep the camera pulled back and the camera angle wide in order to get the context, only if mother is very near. Otherwise, film the child, and fill the screen with the child. Also, important is excellent audio. Sound quality should be such that the child's utterances can be clearly understood, even if the child is speaking softly.

The attachment coders need to know the exact moment that the mother enters the room. Since the mother's entrance is not always on camera, and we do not want to knock loudly just before the door opens, as at the 15 month assessment, the camera person needs to quickly pass her/his hand in front of the lens at the moment the door opens and the mother is visible to the child. All that is required is a quick sweep of the hand in front of the camera lens at the appropriate time. The coders can detect this moment in slow motion. Don't cover the lens for even a second!"

4. Snack

Although there are no current plans to code the snack as part of the common protocol, all sites should videotape the snack session. Following the second reunion, videotaping should continue when the visit coordinator brings in the snack tray. During the snack, the video image should include both mother and child, if at all possible. The table and chairs for the snack should be arranged so as to maximize the opportunity to have both the mother's and the child's faces on the screen as well as bodies. If it is not possible to get both mother and child on the screen, focus on the child with regular "scans" back to the mother. While filming, adjust the lens so that the images of mother and child fill most of the screen. Pictures of the carpet or the cracker will not help coders in the future!

5. Self-control

Begin taping when the instructions begin. Zoom in as closely as possible on the child, keeping face and arms and the "forbidden" toy in view. If child leaves the area where the toy is, follow the child.

6. Three Boxes

Keep both the mother and child in view, if at all possible. Stay close enough in (visually) to be able to see facial expressions, but not so close that you miss gestures, body position changes, etc. Children generally express affect with their entire bodies (mothers, too, but usually not as dramatically). Try to get both partners' facial expressions simultaneously; this is best achieved in silhouette positions. If, during the course of the interaction, both mother and child move such that they cannot be in the picture simultaneously, keep child in the picture, zooming back as much as you can while still getting child's facial expressions.

Make certain that the mother and child are in focus. Use auto-focus if you can be certain that nothing will come in between the camera and the mother and child, throwing your focus onto something extraneous. If you use manual focus obtain a sharp focus by making adjustments with the zoom up close. Zoom back out to the proper distance after focusing.

Once you have the appropriate camera location, zoom distance, and focus, make further adjustments only if necessary. Tinkering with the zoom and focus over the course of the observation will make the coder's task more difficult. However, it is very possible that you will need to make adjustments. Both mother and child behavior must be rated on the qualitative scales. To make these ratings, coders must be able to observe both mother and child on the tape. Therefore, try to keep both mother and child in view. If they are too far apart, follow the child. Try to keep the mother in view as well if the child moves away. Do this by first zooming back slightly for a "bigger picture" and, if necessary, moving the camera. The camera operator should continuously monitor the video image to make certain that the mother and child continue to be filmed properly.

D. Videotape Malfunction

1. Solitary Play

If there is a camera malfunction during the solitary play procedure, the following rules should be followed.

a. If there are at least 10 minutes of the solitary play procedure on tape (from the time the child first touches a toy), then the tape is codeable.

b. If the camera operator suspects there is a problem during the procedure, then he/she should continue filming until 10 minutes have been filmed. At this point, s/he should check to see if the child's play is being recorded on the tape. If so, the tape should be fast forwarded to where taping was stopped and taping should continue until the end of the play session. If there is a malfunction, the camera operator should knock on the lab door, stick his/her head in the room, and inform the examiner that a video malfunction has occurred. At this point, the examiner should terminate the solitary play session, pick up the toys (foregoing cleanup), and proceed directly to the procedures for administration of the Reynell. While the Reynell is being administered, the mother should fill out the CBCL. While the visit coordinator administers the Reynell, the camera operator should try to get the video system to work. If this proves impossible, the visit coordinator should be informed and proceed directly from the Reynell to the snack followed by the PPVT, Television Viewing Interview and growth measures. If the video equipment is working, the examiner should proceed as if everything had gone smoothly, moving on to the

Separation/Reunion, Snack, Self-Control, 3-Boxes procedure, PPVT, TV Interview and growth measures. The solitary play toys should then be laid out once more and the child given the opportunity and encouragement to play with them. After the full 15 minutes of play has been recorded (including any earlier play that was video recorded successfully), the clean-up can be administered. Once this is done, the session is complete.

2. 3-Boxes Mother-Child Interaction

If the camera operator suspects video malfunction, s/he should stop recording after five minutes and check the equipment. If the procedure is being recorded, s/he should continue recording where s/he left off. If no video record is being made, the camera person should interrupt the 3-Boxes session, inform the examiner of the malfunction, and the session should be terminated. The examiner should then proceed to the PPVT, TV Interview and growth measures. If the equipment can be fixed, the 3-Boxes materials should be initiated again. If the video equipment cannot be fixed, the 3-Boxes assessment data will be treated as incomplete. The visit coordinator should apologize to the mother and try to reschedule at a later date.

V. POST-VISIT ACTIVITIES

A. Documenting the Visit

The Visit Coordinator should enter any pertinent information on the family and the visit in the site's Contact Log

Book. The Lab Visit Log Form should be posted and filled out by the lab staff. It will be used to keep track of the different tasks and responsibilities. Do not send it to the DCC. Each site may modify as needed.

B. Check the Data

After the visit is completed, the camera person should check to make sure that the videotape is codeable. The Visit Coordinator should check over the Reynell, PPVT-R, Television Interview questionnaires, and the growth data to make sure all the information is correct and complete.

C. Cleaning Up After the Visit

The Visit Coordinator is responsible for insuring that the toys and lab are clean after the visit. If necessary, the toys should be washed using hot water and dishwashing detergent. The scale should also be cleaned or the paper covering the bottom of the scale should be changed after each child is weighed. The snack materials, chairs and tables should be cleaned. The 2-way mirror should be cleaned after each visit.

VI. ENCOUNTERING UNUSUAL CIRCUMSTANCES

Any number of circumstances can arise which could potentially derail the successful implementation and completion of the laboratory visit. Listed below are several possible problems that might be encountered and recommended solutions. It is impossible to anticipate all potential problems. The Visit Coordinator should thus maintain an attitude that permits "thinking on his/her feet" in order to successfully confront challenges that might arise. Foremost to keep in mind are (a) the needs of the mother, child, and family and (b) our desire to obtain high quality data. Solutions that seriously discomfort families and breed resentment which could undermine further participation in the project must be avoided. At the same time, however, the visit coordinator must be prepared to work hard to find a solution that will enable him/her to obtain high quality data consistent with the other sites.

A. Video Malfunction

Video cameras should be tested an hour before the visit. If the equipment is not working and cannot be fixed and another camera is not available, then the family should be called and the visit rescheduled. If the family cannot be contacted before they arrive at the playroom, the Reynell, PPVT-R, Television Viewing Interview and the questionnaires may be administered with the remaining procedures rescheduled or the entire visit can be rescheduled. For information on video malfunction during specific procedures see Chapter 29.1, IV.D.

B. Family has Difficulty Coming to the Laboratory

Sites should make every effort to make sure the family is able to come to the laboratory. Transportation can be provided. Staff should be flexible about working whenever the families can come (evenings, weekends, schooldays, whatever).

1. Mother has child care difficulties

If there are siblings who need to be cared for during the visit, offer to pay for babysitting or provide someone at the laboratory to babysit the siblings during the visit.

2. Transportation to the lab is a problem

If the mother does not have a car, offer to pay for a taxi to bring the mother and child to the playroom. Arrange for free parking and reimbursement for mileage for mothers who drive a car or who have someone else drive them to the visit.

3. Child Arrives Tired or Ill

If the child is tired or ill, the visit coordinator will need to judge whether the visit should be canceled and rescheduled. The visit should be rescheduled if the visit coordinator believes that the child's behavior will be seriously affected by the child's condition.

4. The Family Does Not Arrive

If the family does not arrive at the scheduled time, the visit coordinator should call the home to determine if the mother forgot or is having difficulty with transportation. If the mother forgot the visit, the visitor should first attempt to have the mother come immediately. Otherwise, the visit should be rescheduled. If the mother is having difficulty with transportation, the visit coordinator should arrange for a taxi and pay for the taxi upon its arrival.

C. Rescheduling visits

The visit may be rescheduled as many times as necessary. However, the visit should take place before the child is 38 months 0 days of age. If a visit cannot be completed during this window, then it can and should be completed during the exception period between when the child is 38 months 0 day and one day before 41 months 0 days old. Then, these data must be flagged as late and an Exception Period Data Collection Approval Form (Form DM-G) needs to be completed and sent, with the data to the Data Coordinating Center. Visits should not take place on or after the child is 41 months 0 days old. This assessment is our most critical outcome measure, and we should go to great lengths to obtain it if at all possible.

D. Child Needs to Go to the Bathroom

Ask the mother to take the child to the bathroom before beginning the session, but do not encourage her to insist if the child is reluctant. Bathroom breaks are scheduled at two points in the visit. If the child needs to go to the bathroom at another time during the session, interrupt the procedure have the mother take him/her. Do not ask the child to wait. Children at this age often have somewhat fragile control, and they can be very distressed if they have an accident. It is a good idea to have some clean children's underpants available. If the child wets or soils his/her underwear, ask mother to take him/her to the bathroom and help the child to finish going to the bathroom and clean up. Then give the child some clean underwear.

If the mother takes child to the bathroom during the Reynell, ask her to bring child back to the testing room and then return to her seat and work on her questionnaires.

If child appears to need to go to the bathroom during the time she/he is alone, follow procedures in Section 29.3.

E. Child impedes procedures

A variety of reasons may cause a child to be an unwilling participant in procedures. For instance, a shy child may be reticent to start playing quickly during the Solitary Play procedure or a child's level of distress may curtail the Separation/Reunion procedures. Although care must be taken to complete all procedures to the degree possible (see Trouble Shooting section in subsequent chapters for details) Visit Coordinators should be sensitive to the needs of the family. Maintaining rapport is extremely important. Do not ignore the child or the discomfort mothers often feel when their child is not doing what is expected. Often a tactful acknowledgement of the child's shyness, distress etc. is sufficient. The mother should be made to feel that her child's behavior is not unusual.

Saying something as simple as "We'll give CHILD some time to feel comfortable while I talk to you about the visit" will put many mothers at ease if their child does not play immediately during Solitary Play. A sympathetic statement, such as "I hope that wasn't too hard for you" following a child's distress during Separation/Reunion will allow the mother an opportunity to make any comments she feels are needed. Similar comments should also be directed towards the children to acknowledge their feelings. Visit Coordinators should handle all such situations as they arise during a visit.

Occasionally during solitary play, a child will display aggressive behaviors. Aggressive behaviors include destructive or inappropriate behaviors such as kicking or hitting, throwing things, etc. The VC should evaluate the severity and persistence of these behaviors as well as the likelihood of refocusing the child on the toys. The VC should use his or her best clinical judgement to handle the child's aggressive behavior and to terminate the session if necessary.

F. Person being interviewed is not child's mother, but is child's primary caregiver.

Complete the Cover Sheet (Form to be developed) for primary caregivers other than mother. If the person being interviewed is the father, do all of the laboratory procedures in the same way as you would with mother. If the person being interviewed is someone other than the father, do all of the laboratory procedures except the PPVT-R with that person.

VII. OVERVIEW OF THE TRAINING FOR THE 36-MONTH LAB VISIT

Training for the 36-month lab visit will occur in September 1993 in Seattle. This training will occur over two full days (a stay of three nights). Research assistants should arrive the night before the training.

Prior to the formal training, RAs should study this manual. They should then videotape all procedures in two pilot sessions. Details of deadlines and where to send tapes will be distributed to all sites in the spring of 1993. These tapes will form a basis for discussions at the training meeting as to how a range of situations should be handled.

Major goals of the training are for RAs to be able (a) to conduct the procedures correctly, (b) to create a comfortable atmosphere for the child and mother and (c) to know how to respond to situations that arise when the child is not doing what is expected.

After the training, each RA will follow instructions to be certified for each procedure as discussed in certification manuals for individual procedures.

Appendix A: 36-MONTH LAB SEQUENCE OF MATERIALS FOR EACH PROCEDURE

REMAINS IN ROOM	BRING INTO ROOM	REMOVE FROM ROOM
	Solitary Play	
	Solitary Play Toys 2 adult chairs Timer Poster of activities Comings and Goings instructions (Card B) Clean-Up Instructions Card (Card A) (Flat-weave throw rub if floor is not carpeted)	
	Clean-Up	
Solitary Play Toys 2 Adult chairs Timer Poster of activities (Flat-weave throw rug)	Clean-up Basket	Timer Comings and Goings instructions (Card B) Clean-Up Instructions Card (Card A) (if mother returns it)
	Separation and Reunion	
Adult chair for mother Other Solitary Play toys in basket Poster of activities	Bean bag chair Little people schoolhouse Separation reminder card for mother (Card C) Comings and Goings Poster	1 adult chair Barn and Silo (Flat-weave throw rug)
	Snack	
Adult chair for mother Poster of activities	Child-sized table Child-sized chair Snack tray with Snack	Other Solitary Play toys in basket Bean bag chair Little People Schoolhouse Separation reminder card for mother (Card C) Comings and Goings Poster

REMAINS IN ROOM	BRING INTO ROOM	REMOVE FROM ROOM
	Reynell/CBCL	
Adult chair for mother Child size table Child size chair Poster of activities	Adult chair for Reynell Kit Chair for Visit Coordinator Reynell Kit Reynell Scoresheet 2 Writing Boards Small adult size table for mother 2 Pencils Magazines CBCL Card D - reminder to mother (attached to table or writing board) Timer	Snack tray and snack
	Self Control/ASBI	
2 Adult chairs Small adult size table for mother 2 Writing Boards Card D - reminder to mother CBCL Reynell Scoresheet 2 Pencils Timer Poster of activities Magazines	Solitary Play toys (minus barn and silo) in basket Ski Boat Crocs in drawstring bag ASBI Flat-weave throw rug (if carpet is plush)	Reynell Kit Child size table Child size chair Visit Coordinator's Reynell Chair

REMAINS IN ROOM	BRING INTO ROOM	REMOVE FROM ROOM
	Three Boxes	
2 Adult chairs Poster of activities (Flat weave throw rug)	Table (adult size) Clock Throw rug (if not already in room) End table with magazines Red Box which contains paper, markers and stencils (see below) Blue box which contains cash register and dress-up clothes (see below) Green box which contains Lego set and photograph (see below) 8-Marker Box of Crayola Washable Markers Tablet of Blank Paper Set of 4 Stencils (rabbit, penguin, dolphin, elephant) Dress-Up Clothes (Pair of Men's Shoes, Pair of Women's Shoes, "Flashy" Vest, Cape) Toy Cash Register (without register tape) Duplo Blocks and Figures in container Picture of constructed Duplo figure	Solitary Play toys in basket Ski Boat Crocs in drawstring bag ASBI CBCL Self-Control reminder card Timer 2 Writing Boards 2 Pencils Reynell Scoresheet Small adult size table for mother Card D - reminder to mother Magazine(s)

ADDITIONAL PROCEDURES

The following 3 procedures may be conducted wherever is convenient, using the materials listed below.

PPVT-R
1) Examiner's Manual
2) Stimulus Pictures
3) Record Form (Form M)
4) Pencil
5) Adult size table
6) 2 Adult chairs
7) Stopwatch

TELEVISION VIEWING INTERVIEW
1) Interview Form (Form 38V)
2) Writing Board
3) Pencil
4) Response Card 14 for Mother
5) Response Card 14 for Interviewer
6) List of Public Television Shows for mother (Card 15)
7) 2 Adult Size Chairs

GROWTH MEASURES AND COMPLIANCE
1) Weight/Height Form (Form 24G)
2) Growth compliance Form (Form 38C)
3) Pencil
4) Detecto Physician's Scale Model #437)
5) Yardstick
6) T-square
7) Sticker for child
8) Weight/Height card for mother
9) Writing Board, if needed

Appendix B: MOTHER INSTRUCTION CARDS

Card A: Clean-up Instructions

Card B: Comings and Goings Explanation

Card C: Comings and Goings Reminder Card

Card D: Reynell/Self-Control Reminder Card

ADDENDUM TO CHAPTER 29.2

PROCEDURES FOR SOLITARY PLAY AND CLEAN-UP

Play Materials

It is important that all of the sites use the same toys for the Solitary Play procedure as stated on page 3 in the manual. Please note that this includes all of the components of the Fisher price barn set. These pieces should include the barn, the silo, the fences, the two pieces of the tractor, the hay baler and the piece of hay, a horse, chicken, sheep, pig, cow, the man farmer, and the woman farmer.

It has also been requested that the clothing for the girl doll that is used in Solitary Play be standardized . Effective March 10, 1994, all female dolls should be dressed with white leotards or tights underneath their dresses. This issue is important at 36 months because the children are engaging in higher levels of play that may involve pretend sequences about changing the doll's diaper or clothing. The white leotards/tights were suggested because it makes the girl dolls' clothing more similar to the boy dolls' clothing.

It has also been noted that at some sites the baby bottle, that is also used in the Solitary Play procedure, was not working. This means that the "milk" was not running down the sides of the bottle when turned upside down. If this happens it is important to get a new bottle since whether or not the toy is working may effect how much time the child engages with that toy.

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CHAPTER 29

Section 2

PROCEDURES FOR SOLITARY PLAY, AND CLEAN-UP:

36-MONTH LABORATORY ASSESSMENT

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CHAPTER 29

Section 2

PROCEDURES FOR SOLITARY PLAY AND CLEAN-UP: 36-MONTH LABORATORY ASSESSMENT

I. OVERVIEW OF SOLITARY PLAY

The purpose of this procedure is to obtain a sample of children's self-directed exploration/play in order to measure the child's sustained attention to objects. The sample play behavior may also be coded to determine the level of sophistication of the child's activity. Toward this end, each child will be presented with a set of play materials specifically chosen to permit a variety of play activities that can be scaled from less to more cognitively sophisticated. Children will be allowed to explore/play with these materials for a total of 15 minutes. Most 36-month-olds find the opportunity to explore these toys in a comfortable setting (i.e., mother present) pleasant and have little difficulty remaining involved with the materials for 10-15 minutes (though see trouble shooting later in this section).

Because Solitary Play is the first formal activity during the lab visit, the time is used not only to observe children's play, but also to inform/remind mothers about the sequence of events in the lab session.

II. MATERIALS AND ARRANGEMENT

A. Play materials

1. A 13" doll matched with child for gender and race. (Same as doll used for 15 and 24 months.) The doll should be placed in a seated position.

2. 1 5" bottle for the doll. (Same as that used at 15 and 24 months.) The bottle should be placed standing

3. A set of kitchen items:
   muffin tin
   large plastic bowl
   aluminum cooking pan
   wooden spoon

4. 6 craft sticks

5. A 15" x 15" red bandanna
   Bandanna should be folded into a rectangle (in half and then in half again and then in half again)

6. A set of large wooden blocks:
   Childcraft Tabletop Unit Blocks, #15396, single set at $44.50, pg. 58 from childcraft, 1-800-631-5652. Each site should order a set.

Unit Name	# In Set	# To Be Used in Solitary Play
B. Circular Curve	2	1
C. 1/4 Circle	2	1
D. Half Unit	8	1
F. Double Unit	8	4
G. Unit	8	4
H. Arch and	1	1
1/2 circle	1	1
I. Large Triangle	4	0
J. Small Triangle	4	1
M. Ramps	4	2
N. Small Column	4	2
letter not listed		
1/2 small column	4	2
V. Half Pillar	4	2
W. Pillar	4	2
Total of Blocks	58	24

The blocks should be placed on the floor in a pile. Do not construct anything out of the blocks or make them look as though they are arranged in any particular way.

7. 1 miniature car and 4 people for the car
   The people should be placed next to the car

8. Set of 4 plates for serving food (from the tea set used at 24 months)
   The plates should be placed next to each other (not stacked) so that they form a square.

9. 3 dinosaurs

10. Fisher Price barn set with animals -- #C2992-2555, each site must purchase.
    The Barn door should be turned so that it faces the child seated in the center. The animals and equipment should be lined up in front of the barn (order of the pieces is not important). The fence should be placed in the green area on the left side of the barn where it fits. This will enable children to put animals in this ready-made pen.

Each child will be presented with a doll that matches the child's gender and racial background. As the sample composition in each site is already known, each site will prepare all the dolls it needs in order to match dolls with children. If no doll representing the race of the child is commercially available, the child's mother will be consulted prior to entering the playroom and her wish regarding the race of the doll will be respected.

B. Room Arrangement

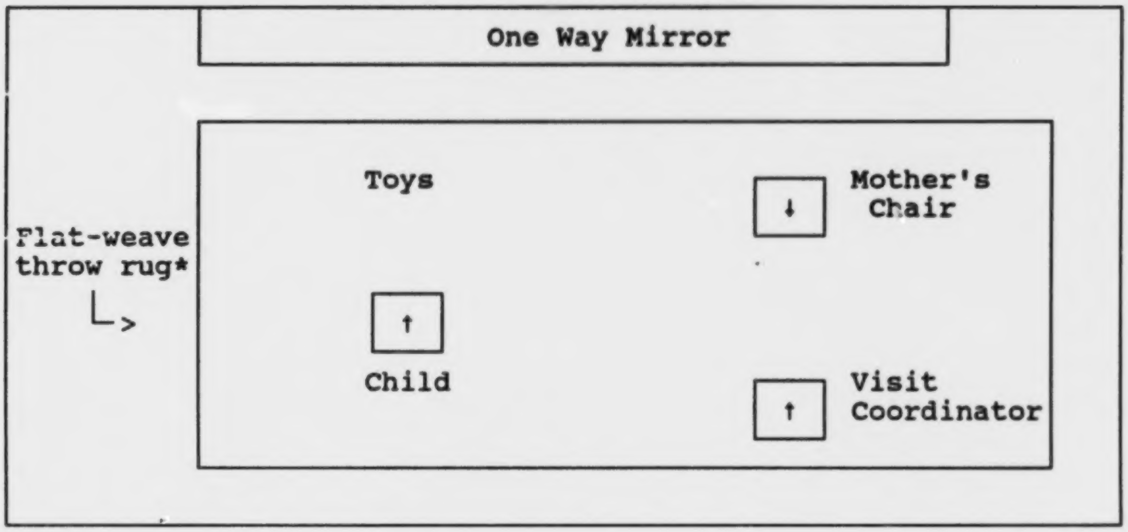
The toys will be placed in a semicircle with item # 1 on the left most and item designated as # 10 at the right most as shown in Figure 24.1. There will be space of an adult's hand width between objects that are not part of a set as designated by the numbers above. Toys that are part of a set will be placed in virtual contact with each other from the child's point of view when the child is seated at the semicircle. The animals and farm equipment that are part of the farm set should be placed in front of the barn. The fence pieces should be placed to the left of the barn to form a pen. When sitting at the center of the semicircle the child should be able to see each toy. If the floor is not carpeted a rug should be placed in the Solitary Play area.

The mother's chair should be positioned no more than two feet away from the toy closest to it. The chair should be positioned so that the mother faces the visit coordinator and her back is facing the one-way mirror through which the videotape is being made. With this arrangement, the mother's face can be seen by the child from the center of the semicircle of toys. The visit coordinator's chair should be positioned so that the child would have to move his/her head or body around to see the coordinator's face. See Figure 1 for room and toy set up instructions.

No interesting distractions should be present. Wastebaskets and other things on floors should be removed before the session. Interesting drawings and other distractions should be out of the child's view. The basket for the clean-up task should be left outside the Solitary Play room, as should all other materials required for subsequent procedures.

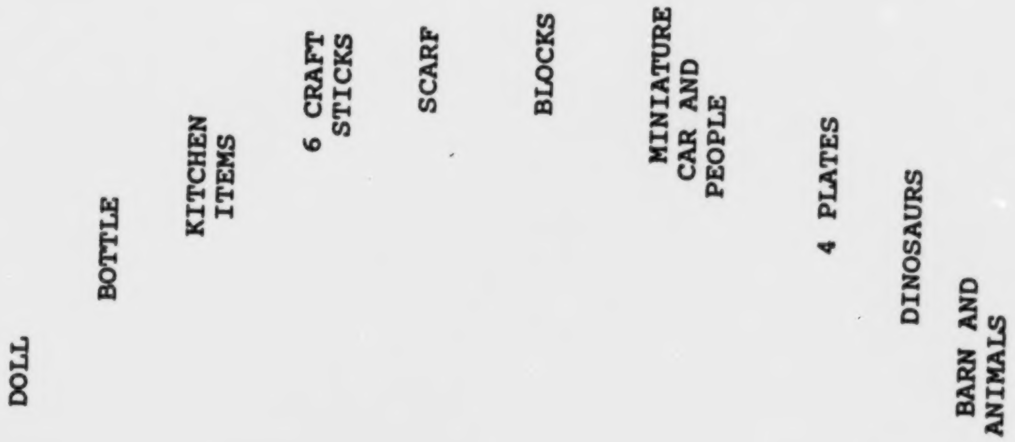
FIGURE 1

GENERAL LAYOUT FOR SOLITARY PLAY


One Way Mirror
Toys
Mother's Chair
Flat-weave throw rug*
Child
Visit Coordinator

*if floor is not carpeted

POSITIONING OF TOYS


DOLL
BOTTLE
KITCHEN ITEMS
6 CRAFT STICKS
SCARF
BLOCKS
MINIATURE CAR AND PEOPLE
4 PLATES
DINOSAURS
BARN AND ANIMALS

III. PROCEDURES FOR INTRODUCTION AND SOLITARY PLAY

Before going to the playroom, suggest to the mother that she take the child to the bathroom. Do not insist or make an issue of it, however. Also, make sure the child is not carrying a bottle of milk, juice or the like, chewing gum, or doing anything else that might distract him/her from playing.

After greeting the mother and making her feel at ease (as described in Chapter 29.1, III.E), and before entering the Solitary Play room prepare the mother and child for the Solitary Play procedure. The mother needs to be informed that she and her child will enter a room with a one way mirror and that she will be shown where to sit. The VC should also inform the child about the procedures prior to entry into the playroom.

The VC should say something like,

"We are going to do a lot of different things today. When we go into the playroom, there will be some toys on the floor. I'd like you (to Mother) to sit down in the chair I'll show you.

(To Child) *Do you remember how the last time you were here, you played with some toys on the floor, while your Mom and I talked? Well, we're going to do that again this time.*

(To Mother) *You may remember this from last year, I'd like CHILD to play with the toys while I explain the rest of the session to you. I'll give you the specific instructions when we get inside. When we go into the* *playroom, please just ask CHILD to sit in the middle of the semi-circle of toys. If he/she doesn't want to sit down, that's OK. We would like her/him to face the mirror as much as possible."*

Take them into the playroom. If the child indicates that he/she wants to play immediately, ask mother to lead him/her to the center of the semicircle of toys. Otherwise, ask mother to sit in the chair facing away from the one-way mirror and give the child time to feel comfortable. Say to child, "You get to play with the toys while I talk to Mom about some things I need to tell her and ask her."

(To Mother): *"While CHILD plays for about 15 minutes, I will explain what we will do today. First, I want to remind you that the goal in this first 15-21 minutes is to have CHILD play with the toys without either of us naming them or suggesting toys for him/her to play with or things to do with the toys. There will likely be times when he/she looks up to you, shows you a toy, comes over to you or otherwise seeks your attention. What we want you to do is respond to him/her in a way that lets him/her know that you are here and interested in what he/she is doing, without doing anything to encourage his/her focus upon you rather than the toys. I'll try to help you. When I see CHILD wants to show you something I will say something like 'just smile and tell him that it is nice;' If I see him/her come over to you, I will tell you just to lean* *forward, take what he/she has to offer, and then put it back on the floor beside the your chair. I may ask you to just lean over and give him a pat if it seems like he/she wants something more; and if he/she is persistent in his/her visits to your side, I may even suggest you pick him/her up for a little bit and then put him/her back down by the toys. Please feel relaxed and comfortable. Sometimes children will ask you for information or for assistance. If CHILD does ask you something try to answer in general terms. I'll help you by suggesting what you can say in response. I will also be monitoring his position to make sure he/she is facing the mirror. If he/she gets his/her back turned to the camera for too long I will ask you to help me to move him/her. Lastly, as we are talking it is important that we do not talk about your work situation or CHILD's childcare situation. Don't worry about remembering all these instructions. I'll help you out as the need arises. In short, what I would like for us to aim for is a situation in which the two of us are talking as CHILD plays at our feet. Before I go on to talk about the rest of the session, do you have any questions at this point?"*

If the visit coordinator wishes to impart the detailed instructions given above prior to entering the playroom, this is acceptable provided that the visit coordinator reminds the mother of the instructions in abbreviated form once inside the playroom. However, for purposes of certification, it is necessary to impart the detailed instructions inside the playroom.

If after about a minute the child has not touched a toy, then the visit coordinator should draw the child's attention to the toys by saying his/her name, making eye contact with the child and then just tapping with a finger on a few of the toys. This is all the visit coordinator should do with the toys.

If child comes to Mother, shows her toys, or talks to her about the toys, let her respond. Remember, however, that 3-year-olds understand what you are saying, so you will need to keep your suggestions brief and clear. Don't talk about the child as though he/she were not there. Suggest that she say something brief, pleasant, and neutral like "That's nice" or "Yes, I see." If child hands her a toy, ask her to take what he/she has to offer and then put it back on the floor beside the other toys. You may ask her to just give CHILD a pat if it seems like he/she wants something more; and if he/she is persistent in his/her visits to her side, you may even suggest she pick him/her up for a little bit and then lead him/her back to the toys. If the child repeatedly tries to gain mother's attention by bringing toys or talking to her, you can also remind child that you and Mom need to talk right now. Say something like, "I need to talk to Mom now. You and MOM will get to do something together later."

These procedures are summarized in figure 3, The Solitary Play Flow Chart. If the child stops playing use the strategies for re-focussing discussed under Troubleshooting and summarized in the Flow Chart.

The play session will be officially started at the time the child starts engaging with the first toy. "Engagement" occurs when the child shows intent (or focused) visual and tactile exploration of objects that lasts at least 3 seconds. The session will be terminated 15 minutes after the initial point of engagement (see "Videotaping Solitary Play" for exceptions to this.) The camera operator should begin the clock on the tape just before the child enters the room.

After explaining Solitary Play the Visit Coordinator should continue with an explanation of the remaining activities.

> *"Now let's talk about what else we'll be doing today. You can look behind me to the poster labeled 'Playroom Activities' (see Figure 2) as I tell you briefly about what we have planned. Please feel free to interrupt me at any time if there is something you do not understand or are curious about."*

Figure 2

ACTIVITIES OF THE DAY

1. Child plays.
2. Cleanup.
3. "Comings and Goings"
4. Snack.
5. Language measure with child. Mother completes questionnaire.
6. Waiting task with child. Mother completes questionnaires.
7. Three boxes
8. Interviews with mother. Child plays.
9. Growth measures.

"After CHILD has played for about 15-20 minutes, we will go to the other activities described on the chart on the wall."

"At this age, children understand almost everything that is being said around them, so we will be using several cards to explain things to you without CHILD hearing the instructions. Later in this play session, I will give you cards to explain the second and third activities on our chart. The fourth activity we have planned is a Snack."

"After the snack, I will give CHILD a standardized measure of language development. During this activity I will be showing CHILD different toys and pictures. Some of the

things I will be doing with CHILD will be quite easy for her/him while others will be difficult. We do not expect CHILD to do all of the things I will show her/him so don't worry if she/he does not do everything. We will have a questionnaire for you to complete while CHILD and I are playing together. If you finish before we do, you can either read a magazine or watch what CHILD and I are doing. If you want to watch, please make sure that you don't try to help CHILD with any of the questions or repeat any directions. We want CHILD to focus on me and what I am saying and doing.

The next activity will be a waiting task where I will show CHILD a new toy. During this activity we have another questionnaire for you to complete. Again, if you finish it before we are done, please do not try to help CHILD or repeat any directions."

Then you and your child will have a chance to play with some toys in the Three Boxes. Following that, you will be interviewed and given a measure of word knowledge. Then CHILD will be weighed and measured. Do you have any questions?

The examiner must explain these events in such a way that the child is not alerted that separations will occur. It is important that when the separations occur, they appear to be initiated at the will of the mother, and not the examiner.

Some children are easily disrupted by the silence which accompanies the mother's reading for the long explanation of Comings and Goings. Since we want to minimize this problem as much as possible, Card B (Comings and Goings Instructions) should be given to the mother after the child has "played" for the 10 minute minimum required for codeable Solitary Play data. After this point in the Solitary Play session, the Visit Coordinator should choose a time when the child is either particularly engaged (or disengaged) with the toys to give the mother Card B. Visit Coordinators should use their judgement as to when the best time for this would be. Care should be taken to allow Mother sufficient time to read the entire card before the end of the Solitary Play session.

The Visit Coordinator should say, "Before we go on, take some time to read this card about 'Comings and Goings.'" Then hand the following card (Card B) to mother:

Card B:

Comings and Goings

In this part of the study, we are interested in children's responses to brief separations from their mothers. Our focus is on your child. We are writing your instructions because we don't want to talk about your "Comings and Goings" in front of your child.

Comings and Goings begins after the cleanup. It has 6 parts:

1. You and your child will be in this room for about 3 minutes. Both of you can do whatever you'd like. However, please remain in your chair whenever possible.

2. After about 3 minutes there will be a knock, and that will be your signal to leave the playroom. How you leave is up to you. You may do or say whatever feels most comfortable for you and your child. The only thing we ask is that your child stay in the room.

3. You will go to the observation room where you can watch your child.

4. After 3 minutes, you will come back into the room.

5. After several minutes there will be another knock. Again, how you leave the playroom is up to you. Your child should remain in the playroom.

6. You will be out of the room 5 minutes, and then return.

If your child gets upset while you are gone, you may return at any time.

You do not have to memorize these instructions. There will be reminders as we go along.

IV. PROCEDURES FOR CLEAN-UP

Once 15 minutes of solitary play have been recorded, or the child has lost interest in the toys and cannot be refocussed, it is time for the clean-up. The purpose of this assessment is

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to determine how mother and child manage the cleaning up of the solitary-play toys.

Clean up Instruction. When the solitary play session is finished, the VC will present the mother with card A and say, "This card tells you what we will do next. Please read it carefully. Then tell me if you have any questions." (The play session is finished after 15 minutes unless it needs to be terminated for any reason listed in the trouble shooting section below.) If the VC has left the mother and child alone in the room, he/she should come back at the end of the session and present card A.

Card A will say

> *"Next, I would like you to get your child to clean up the toys. Please have (him or her) put the toys in the basket that I will bring you. You can manage the clean-up however you like, but we want your child to be involved.*
>
> *I will be out of the room during the clean-up and return in 5 minutes."*

When she finishes reading, ask if she has any questions. Try to avoid alerting the child to the instruction regarding cleaning up.

If mother asks if she can help with the clean-up or whether we just want the child to do the clean-up, say something to the effect of "Please feel free to manage the clean-up as you feel most comfortable, but we would like to see CHILD involved." We don't want to tell the mothers directly that they can help, but we want them to know, if they ask, that the clean-up is not something the child has to do all by him/herself. We do want mothers to know, though (if they ask), that the child should participate and thereby reduce the likelihood that mother will do all the clean-up herself.

After the mother's questions have been answered the Visit Coordinator should open the door and bring in the clean-up basket. The basket should be a blue Rubbermaid laundry basket No. 2965. It is a 1 1/4 bushel basket measuring 22 1/2 X 16 1/4 X 10 3/4 inches. After handing the basket to Mother the VC should leave for 5 minutes or until the CLEAN UP is complete, whichever comes first.

The examiner should observe the clean-up through the one-way mirror so that he/she can return to the lab room if all the toys are put away before 5 minutes are up. If, after 5 minutes, the toys are not all put away, he/she should return to the room and help finish the clean-up herself. She should then suggest to the Mother that she take the child to the bathroom. If child does not need to use the bathroom, suggest they walk to it and "try" unless child went earlier. If child is wearing diapers, say, "This is a chance to take CHILD on a bathroom break. There will be other opportunities. How you use these breaks is up to you."

V. TROUBLESHOOTING FOR SOLITARY PLAY

The most important thing to remember throughout the Solitary Play procedure is that the visit coordinator is free to converse with mother and child to help facilitate the goal of keeping the child involved in play. Ultimately, our goal is to create a situation that is both familiar and comfortable, resembling something that might happen at the child's home: mother conversing with a friend and child playing at her feet. Despite the best efforts, problems can arise that undermine the procedure. Below is a list of some problems that may arise and ways to deal with them. Figure 3, The Solitary Play Flow Chart, summarizes the same information (see Appendix A.) Visit coordinators may want to have Figure 3 handy, so they can refer to it during the session.

1. Child Just Sits and Looks at Beginning of Session: At the beginning of the session, a child may be apprehensive about engaging with the play materials and may just sit and look at the mother or visit coordinator. If this occurs for 30-60 seconds, the visit coordinator should get up, tap on several of the toys, and invite the child to play with the toys. It is most important that the visit coordinator not move or manipulate the object in some way that reveals a unique property (e.g., spin wheels on toy), as this is something we might be measuring and if it occurs we want it to be initiated by the child. If the child is not enticed by the tapping on the toys and continues to just sit and look for another minute or two, invite the mother to sit on the floor either behind the child or with the child in her lap.

Reposition yourself so you can continue to talk to the mother without obstructing the view for the camera or making the child uneasy. The mother will continue to sit on the floor for the duration of the session.

On rare occasions a child is sufficiently uncomfortable that he/she will not play, even with the mother sitting on the floor nearby. The reason may be that the child is simply too inhibited by the other adult's presence. If after another minute or two the child is not playing, the visit coordinator makes this appraisal, and it is a judgment call, he/she should leave the room. Before departing, explain to the mother that children are sometimes uncomfortable in the presence of strangers, so this is the reason he/she is going to leave. BE SURE TO REMIND THE PARENT OF THE ROLE SHE IS TO PLAY: MINIMALLY RESPONSIVE, NON-PARTICIPATORY, WITHOUT PROVIDING DIRECTIONS AND SUGGESTIONS FOR PLAY. If the child does not engage with the toys after the visit coordinator leaves the room, the session should not be allowed to continue for more than 8 additional minutes. (Depending on the time the visit coordinator left the room, the session may come to its "natural" end (i.e., 21 minutes total) before the 8 minutes have elapsed.)

2. Child Won't Separate from Mother: Sometimes the child does not want to separate from the mother. It is important not to force the child to separate from the mother, because the whole procedure is predicated upon making the child comfortable. Thus, be alert to mothers who, for whatever reason, are inclined to

over encourage their child to play. If a mother seems intent on encouraging the child to play before the child is ready, the visit coordinator should let the mother know that there is no hurry, and that it is fine for the child to sit with the mother for as long as the child needs. If the child has not separated from the mother after a period lasting 1-2 minutes, the Visit Coordinator will tap on several toys and invite the child to play. If the child does not accept the invitation, the Visit Coordinator waits for another 1-2 minutes and repeats the tapping/invitation procedure. If another 1-2 minutes passes after the visit coordinator taps on several toys, and the child still will not separate, ask the mother to get down on the floor with the child. Tell her she can set the child in front of her or she can have the child sit on her lap. If this happens, reposition yourself so that you can look at the mother, but don't move in a way or to a place that obstructs the camera or adds to the child's uneasiness. It is most important for the visit coordinator, in this and all situations, to maintain a friendly, easy exchange with the mother and child in hopes of putting the child at ease. If the child still does not play after 1-2 minutes, the visit coordinator should leave the room. Before leaving, the visit coordinator should remind the mother of the instructions about what the mother should avoid doing (naming toys, suggesting toys to play with, showing the child what to do with the toys) and that she should be minimally interactive. After leaving the room, the Visit Coordinator should watch the mother and child from behind the mirror. If mother is being too interactive, Visit Coordinator should poke his/her head in the door and remind the mother to be minimally interactive. If the child does not engage with the toys after the visit coordinator leaves the room, the session should not be allowed to continue for more than 8 minutes. (Depending on the time the visit coordinator left the room, the session may come to its "natural" end (21 minutes) before the 8 minutes have elapsed.)

3. Visit Coordinator Misjudges Child's Readiness to Play at Start: If the visit coordinator believes that the child is ready to play and asks the mother to lead the child to the center of the toys, and the child is upset and clearly not ready to play, the mother should be instructed to return to her seat and allow the mother to hold and comfort the child. The visit coordinator will then follow the "Child Won't Separate from Mother" procedure described above, picking up from where she left off before misjudging the child's readiness to play. For example, if the visit coordinator thought that the child was ready to play after she had tapped on the toys one time, the visit coordinator should tap on the toys again after the child had been sitting on his/her mother's lap for 1-2 more minutes. Then after another 1-2 minutes, the visit coordinator should ask the mother to sit on the floor behind the child.

4. Child Stops Playing -- Unoccupied or Self-Occupied: (see definitions below). If the child remains unoccupied for a minute or two, tap on the toys and invite the child to play. If this

doesn't work immediately, ask the mother to verbally encourage the child to play with the toys. If child is far from toys or facing away from them, ask mother to bring child back to the toys and encourage her/him to play with them. If this still does not work, repeat this tapping/encouragement procedure. If after 3 attempts of this procedure to get the child to re-engage with the toys, the child still will not play, terminate the session and move on to the clean-up.

Definitions:

1. A child is unoccupied when he/she is not actively manipulating objects or when he/she manipulates objects in a stereotypical fashion (repetitive, mindless manipulations) and is looking elsewhere.

2. A child is self-occupied when he/she is engaging in activities that do not make use of toys such as running around the room, jumping, singing, or holding a conversation with himself/herself or with an imaginary friend.

5. Child's back to the camera: The visit coordinator will continuously monitor the child's position and evaluate its relationship to the camera. If the child sits and plays with her or his back to the camera for 30 seconds, instruct the mother to tell the child to move around to face the front of the room or the mother. The mother can say something like, "Move around and face the front so I can see your face better." If that does not work immediately, ask her to gently reposition the child while allowing the child to continue playing with the same object(s). The mother or visit coordinator should not pressure the child to move if it is thought that doing so will upset the child and

prevent him/her from continuing to play. In the case of a child who is mobile and constantly moving around, there is no point in repositioning the child. If the child is sitting with his/her back to the camera, but is not engaged with an object, follow the procedures for "Child Stops Playing" (Item 4 above).

6. Child Goes Over to Mother: Sometimes children will interrupt their play to go to see mother. It is our goal to have the child be engaged with toys for as long as possible and thus not encourage mother-child interaction. To achieve this goal, however, the visit coordinator needs to be sensitive and responsive to the child's needs and desires. Thus, when a child gets up to approach the mother, try to anticipate this and remind mother what to do.

6a. Child approaches with a toy: If the child approaches the mother with a toy, remind the mother to accept the toy, say something general such as, "That's nice," and put the toy down on the floor near the other toys (but not necessarily in the semicircle -- the mother need not get out of her chair to put the toy back).

6b. Child asks mother for assistance with a toy: If the child approaches the mother with a toy, and asks the mother to do something instrumental that the child is unable to do for himself/herself (i.e., fix snaps on the doll's clothes, take the spoon out of the tea pot), the mother may help the child. The mother should be instructed to do only what the child is asking and do nothing else with the toy. The mother should be discouraged from doing anything that involves interaction between the mother and child.

6c. Child asks the name of a toy: Children this age are likely to ask their mother or the visit coordinator the names of the toys. If the child asks the name of a toy, he or she should be told that it is "Something for you to play with."

6d. Child Seeking Attention From Mother: If the child appears to need more attention from the mother, tell her just to lean over and hug the child if this seems to be all the child wants. If more seems to be needed, tell the mother to pick the child up and hold him on her lap for 30-45 seconds. If the child seems comforted and ready to play again, the mother can put the child down and encourage him/her to return to the toys. If the child still seems to need attention from the mother, wait 30-60 seconds and tap on the toys and encourage the child to play. If the child does not leave the mother's lap, wait another 30-60 seconds and tap on the toys again. The mother can verbally encourage the child to play too. If this strategy fails to convince the child to play, wait a minute or two and then ask the mother to sit on the floor with the child. If the child still refuses to play after sitting with his/her mother on the floor for a minute or two, the VC should leave the room, reminding the mother of the instructions about what the mother should avoid doing (naming toys, suggesting toys to play with, showing the child what to do with the toys) and that she should be minimally interactive. Visit Coordinator should monitor mother and child from behind the mirror. If mother is being too interactive, Visit Coordinator should poke his/her head in the door and remind mother to be minimally interactive.

If the child repeatedly approaches the mother with a toy, follow the above procedure (i.e., the visit coordinator should start by asking the mother to give the child a hug).

6e. Child stands near mother for extended period: If the child stands next to the mother for a minute or two without offering a toy or indicating that he/she wants attention, the visit coordinator should suggest that the mother hug or pat the child.

7. Mother Telling/Showing Child What To Do: Despite initial directions to the mother about not showing or suggesting behaviors to children, some mothers will do otherwise (mostly inadvertently). The visit coordinator will need to carefully monitor the mother's input and courteously interrupt her if she starts to give specific play directives. The best way to do this is to simply say "remember we want you to just direct the child towards the toys in general and not offer any specific instructions."

8. Child Wanders Away, But Not Toward Mother: Some children, when they lose interest in the toys, will leave the toy play area (rather than approaching the mother). After a minute or two of unfocussed wandering the visit coordinator should tap on several of the toys, call the child's name, and invite him/her to play with the toys. If this does not work immediately, ask the mother

to tell/encourage the child to play with the toys. If the child does not come back to the materials spontaneously, the visit coordinator should immediately ask the mother to bring the child back to the toys, again asking him/her to sit and play with the toys. If after 3 attempts of this procedure to get the child to re-engage with the toys the child still will not play, terminate the session and move on to clean-up.

If the child wanders away to an electric socket (which should be covered) and starts playing with it, the visit coordinator will not wait any length of time before tapping on the toys, calling the child, and inviting him/her to play. Likewise, if the child wanders toward the door, and the visit coordinator believes that the child can open the door and leave the room, she should tap on the toys immediately without waiting for any time to pass.

9. Child Wanders Out Of Camera View: If the child moves into a part of the room that is out of the camera's view and the child is engaged with an object, wait for thirty (30) seconds and then instruct the mother to tell the child to move back to the center of the room. If that does not work immediately, have the mother reposition the child and the toys he/she is playing with in the center of the room. However, if the child wanders into a dead area, but is only standing or moving aimlessly, wait for a minute or two, then tap on the toys, call the child's name, and invite him/her to play. If this does not work immediately, ask the mother to tell/encourage the child to play with the toys. If the

child still does not come back to the toys, the visit coordinator should immediately ask the mother to bring the child back to the toys, again asking him/her to sit and play with the toys.

10. Child Repeatedly Wanders Away: Some children will lose interest in the toys repeatedly. If the child approaches the mother or wanders away more than 3 times and cannot be refocussed except for fleeting periods of time, the solitary play segment of the session should be terminated.

11. Child Seeking Information From Mother or Visit Coordinator: If the child calls to the mother or asks her a question while he/she is playing, the mother should be instructed to be as general as possible in her responses. For example, if the child asks the mother what a certain item is, the mother might be instructed to respond, "what do you think it is?" or "You try to figure it out while I'm talking to VISIT COORDINATOR'S NAME." Children at this age may also ask the mother to play with them. If this occurs, instruct the mother to say something such as, "You play now while I'm talking to VISIT COORDINATOR'S NAME." If the child asks questions of Visit Coordinator, she/he should use the same types of responses as those suggested for the mother.

12. Interruptions: Unanticipated interruptions can occur, for example, if the child needs to go to the bathroom or starts to cry for some reason. In such cases simply make the necessary adjustments (e.g., ask mother to take child to bathroom, comfort child) and then pick up the play session once the child is ready

to go again. Try to obtain a full 10 minutes of play, despite the interruption (e.g., 7 minutes before, 3 minutes after). Only if the child wanders repeatedly and cannot be refocussed should a session be terminated before a full 10 minutes.

13. Security Objects: Some children will come to the play session with some kind of security object (e.g., blanket, doll). Ideally we would like the child to leave such objects in the storage office and not have them down on the floor with the child, but not at the cost of the child being so uncomfortable that he/she will not play. Thus, ask the mother to take the object in question away from the child, but let her know that if the child seriously protests, we will not insist on it. Be ready to tell the mother not to bother if she seems to be too assertive in taking something away from the child. Pacifiers are acceptable in the playroom, if necessary. Bottles and chewing gum are not permitted unless absolutely required by the child.

14. Aggressive Behavior: Occasionally, a child will display aggressive behavior. Aggressive behaviors include destructive or inappropriate behaviors such as kicking or throwing toys, stepping on toys, hitting the mother or VC, stomping feet, pushing the mother's or VC's chair. Sometimes these behaviors are combined with protest behaviors like crying or whining. If a child displays these types of aggressive behaviors, the VC should evaluate the severity and persistence of these behaviors as well as the likelihood of refocusing the child on the toys. The VC should use his or her best clinical judgement to handle the

child's aggressive behavior and to terminate the session if necessary. If it is the VC's clinical judgment that worthwhile solitary play data cannot be obtained from the child, then the session should be terminated.

15. Using Clinical Judgement: While the manual attempts to provide the procedures for problems that may come up during a solitary play session, it is impossible to foresee every possible event that may occur. Therefore, the visit coordinators should use their best clinical judgements in handling any problems that they are faced with during a solitary play session.

16. Videotape malfunction: If there is a camera malfunction during the solitary play procedure, the following rules should be followed.

a. If there are at least 10 minutes of solitary play on tape, then the tape is codable.

b. If during the procedure the camera operator suspects there is a problem, he or she will stop the videotaping and try to fix the problem on the spot. He/she will then resume videotaping to the end of the Separation episode (3 minutes after Mother leaves room). He/she will then report that videotaping of play was stopped, indicating when the stopping occurred. To the extent possible, information about the exact time at which failure occurred and taping resumed will be noted. If the exact time of interruption in taping is not known, an estimate will be provided (e.g., beginning, middle, or end of session).

VI. VIDEOTAPING SOLITARY PLAY

In order to code the videotape for sustained attention and levels of play, it is necessary to see on the screen the child's face, body, and hands as well as any objects that are being manipulated. Consequently, the camera person should adjust the zoom lens so that all of these components are captured by the camera simultaneously. The video image should also include the date and time (to the nearest second). The visit coordinator needs to know which parts of the room cannot be captured by the camera and try to get the child away from these blind spots. The camera is to be started when the child, mother, and visit coordinator enter the solitary play room.

The goal of the Solitary Play session is to obtain 15 minutes of data (15 minutes of elapsed time, not necessarily continuous play) from the time the child first explores a toy. It is important that the timing begin when the child is first engaged with a toy. "Engagement" occurs when the child shows intent (or focused) visual and tactile exploration of objects that lasts at least 3 seconds. The maximum amount of time that the session should run from the time that the mother, child and visit coordinator enter the Solitary Play room is 21 minutes.

Occasionally, a child will need to go to the bathroom during the Solitary Play Session. If this happens, it is still necessary to obtain 15 minutes of data. The time should be stopped when 1) the child requests to go to the bathroom, AND 2) the child disengages with the toys. Do not wait until the child leaves the room to stop the time. When the child returns to the playroom, start the time when the child re-engages with a toy. The time from engagement before the break combined with the time from the engagement after the break should total 15 minutes. You must make sure however, that the total time in the playroom does not exceed 21 minutes.

There will be occasions when it is impossible to obtain 15 minutes of data. On some of those occasions, it will be necessary to reschedule the session. The minimum time requirement is 10 minutes of data (time elapsed, not necessarily continuous play) from first engagement. If there are at least 10 minutes of data, the session does not have to be rescheduled. If this minimum is not reached, however, the session must be rescheduled. There are several reasons why there may be less than 10 minutes of data. First, the visit coordinator may have made a procedural error. Second, there may have been a technical problem. Third, on a rare occasion, a child may not engage with a toy early enough in the play session to be able to obtain 10 minutes of data without exceeding the maximum session length. In such cases, the session may need to be terminated before 10 minutes have elapsed from the first engagement with toys. Fourth, a child may never engage with a toy. Fifth, the session may need to be terminated due to aggressive behavior. In these five cases, it is necessary to reschedule the session.

There is one exception to the above guidelines. A child may initially engage with a toy but then not play for the rest of the time. According to the above guidelines, the solitary play session would usually not be repeated because there is a minimum of 10 minutes of data available after the first engagement. If, however, the child must return to the laboratory to repeat a different procedure, the child should also repeat the solitary play procedure.

VII. CODING

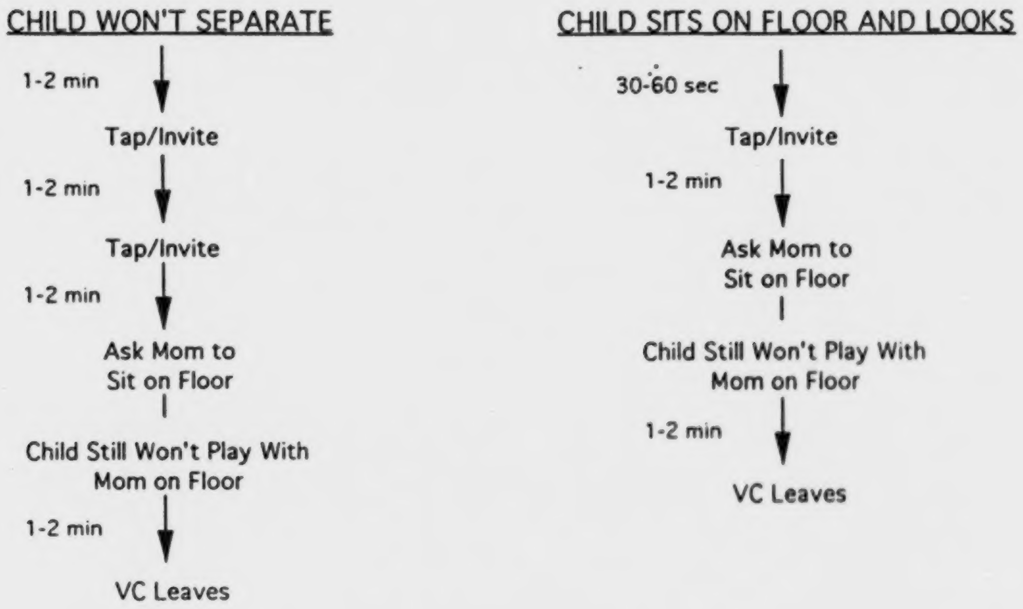
The detailed coding manuals for each procedure are in Chapter 29.12. The Solitary Play will be coded for sustained attention and possibly for level of play. The Clean-up will be coded for compliance. The coding instructions appear in the Sub-manual for Coding Solitary Play and Clean-up.

VIII. APPENDICES

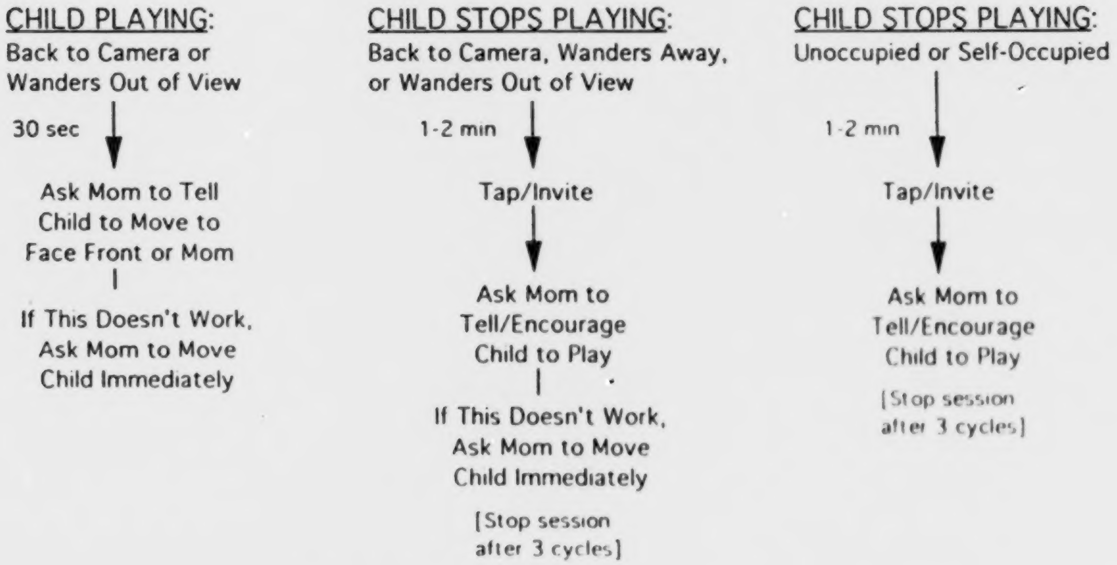
A. Figure 3 -- The Solitary Play Flow Chart

36 MONTH SOLITARY PLAY FLOW CHART

BEFORE ENGAGEMENT WITH TOY

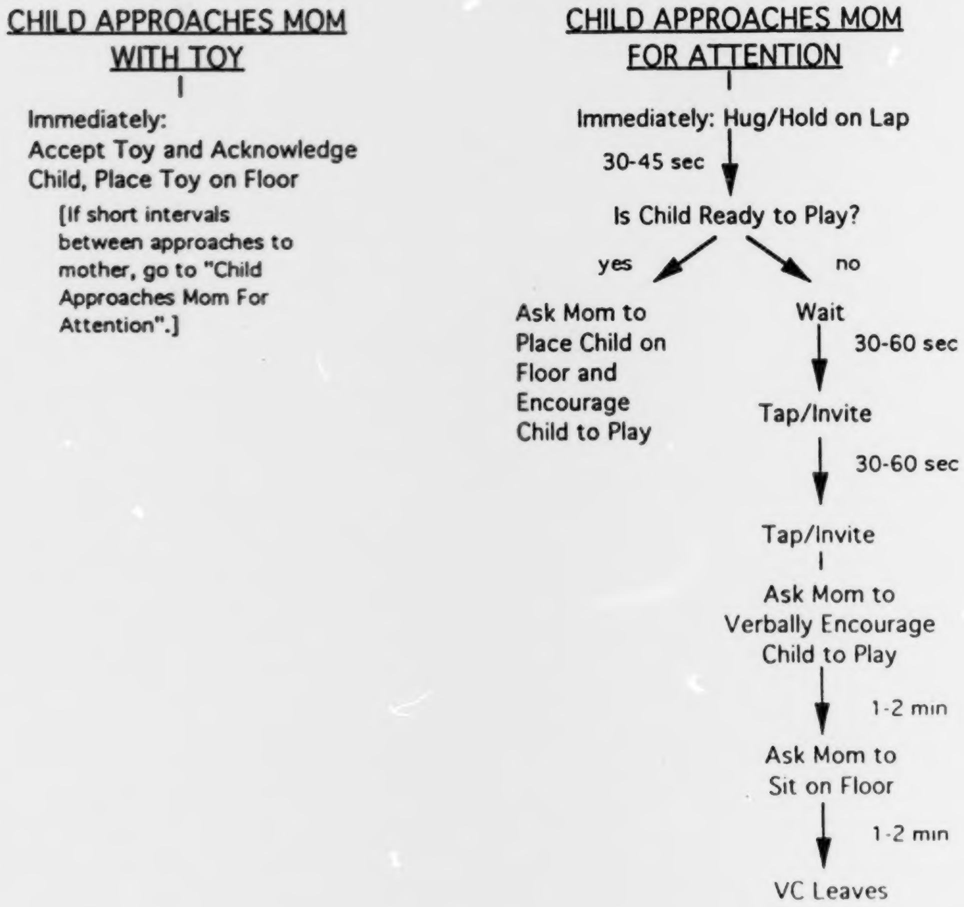

CHILD WON'T SEPARATE
1-2 min
Tap/Invite
1-2 min
Tap/Invite
1-2 min
Ask Mom to Sit on Floor
Child Still Won't Play With Mom on Floor
1-2 min
VC Leaves
CHILD SITS ON FLOOR AND LOOKS
30-60 sec
Tap/Invite
1-2 min
Ask Mom to Sit on Floor
Child Still Won't Play With Mom on Floor
1-2 min
VC Leaves

AFTER ENGAGEMENT WITH TOY


CHILD PLAYING: Back to Camera or Wanders Out of View
30 sec
Ask Mom to Tell Child to Move to Face Front or Mom
If This Doesn't Work, Ask Mom to Move Child Immediately
CHILD STOPS PLAYING: Back to Camera, Wanders Away, or Wanders Out of View
1-2 min
Tap/Invite
Ask Mom to Tell/Encourage Child to Play
If This Doesn't Work, Ask Mom to Move Child Immediately
[Stop session after 3 cycles]
CHILD STOPS PLAYING: Unoccupied or Self-Occupied
1-2 min
Tap/Invite
Ask Mom to Tell/Encourage Child to Play
[Stop session after 3 cycles]

36 MONTH SOLITARY PLAY FLOW CHART

AFTER ENGAGEMENT WITH TOY


CHILD APPROACHES MOM WITH TOY
Immediately:
Accept Toy and Acknowledge Child, Place Toy on Floor
[If short intervals between approaches to mother, go to "Child Approaches Mom For Attention".]
CHILD APPROACHES MOM FOR ATTENTION
Immediately: Hug/Hold on Lap
30-45 sec
Is Child Ready to Play?
yes
no
Ask Mom to Place Child on Floor and Encourage Child to Play
Wait
30-60 sec
Tap/Invite
30-60 sec
Tap/Invite
Ask Mom to Verbally Encourage Child to Play
1-2 min
Ask Mom to Sit on Floor
1-2 min
VC Leaves

ADDENDUM TO CHAPTER 29.3

PROCEDURES FOR SEPARATION AND REUNION

I. Instructions For Handling Difficult Situations in Coming and Going Procedures

In cases where the VC enters the room (due to the mother having trouble leaving the room at the knock or due to the child persisting at the door), the VC must soon thereafter judge the likelihood of being able to leave the room (can the child remain in the room alone?) again. If the VC decides that the child has settled enough, s/he should stand (from either the chair or the toys) and announce, "I'm gonna go get your Mom" as s/he leaves. Do not withdraw abruptly. Gradually withdraw from interaction, but if this seems to precipitate the child going to the door, re-engage. In cases where the VC attempts to leave the room and then realizes that s/he needs to stay after all, s/he can simply stay in the room until the reunion (and should NOT attempt to leave the room again during the separation). These instructions apply to the second separation as well - most importantly, the VC should NOT attempt to leave the room more than once. Another situation might be a separation in which the VC enters and then IS able to leave the child alone again. If during this same separation, the child's behavior causes the VC to have to re-enter the room, then the VC should not even attempt to leave a second time (since the VC has already left the child once during this separation).

Sometimes the child plays a door "game" while he/she is alone in the room. In this case the child becomes quite focused upon the opening and closing of the door, peeking through the opening and giggling. If this happens from the beginning of the first separation, it's probably best for the VC to enter the room and then attempt to leave again if the child settles down. If the VC gets out of the room and the child persists at the door game again, then the VC should re-enter the room and remain until the reunion (since the VC should only attempt to leave once per separation). If, however, the child starts to play the door "game" again and there is very little time left before the reunion is supposed to occur, then the mother should be sent in a bit early (instead of the VC re-entering and then shortly thereafter the mother entering). If a VC experiences a child who plays this door "game" and has had to enter during the first separation and then found that the child either didn't allow the VC to leave again or did allow the VC to leave but only to start the door "game" again, then the VC might try to predict the outcome of the second separation. A judgement can be made as to the effectiveness of the VC even attempting to leave the room again after having to enter during the second separation.

If you know in advance that a certain child tends to dart out of rooms (either from your memory of a past visit with a child or from your experience during Solitary Play/Clean-Up), then it might be wise to plan for the VC to enter the room just as the mother leaves (or attempts to leave) at the knock. Most likely the child will either become distracted by the toys, or the child will continue to flee toward the door even with the VC in the room. If the child does persist to try to dart out of the room, then the VC should try to lead the child away from the door. If this causes distress, which it may, then the mother should enter the room soon thereafter.

II. Sending Videotapes to Seattle

All tapes should be slated "SOLITARY PLAY/COMINGS & GOINGS/SNACK" at the beginning of each recording. Please also have a slate prior to the actual Comings & Goings procedure that gives the child's ID number.

Please attach a note on each tape in which the VC's indication that the mother has returned to the room (passing his/her hand over the lens) occurs more than five seconds after the mother has actually returned.

CHAPTER 29

Section 3

PROCEDURES SEPARATION AND REUNION EPISODES

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CHAPTER 29

Section 3

PROCEDURES FOR SEPARATION AND REUNION EPISODES

I. PROCEDURES FOR SEPARATION

The purpose of this procedure is to conduct a modified Strange Situation in order to assess the quality of the child's attachment to the mother. The guidelines presented here are based on the manual prepared by Cassidy and Marvin with the McArthur Working Group on Attachment (1992), Attachment Organization in Three- and Four- Year Olds: Coding Guidelines.

The procedures are summarized in Figure 1, The Separation-Reunion Flow Chart. After the CLEANUP or the equivalent 5 minutes is finished, the Visit Coordinator invites the mother and child to take a bathroom break. While they are gone, the Visit Coordinator will place the child's bean bag chair along the wall opposite the camera. The mother's chair will be in a corner close to the mirror and opposite the door. The basket of solitary play toys (minus barn and silo) will be in the corner diagonally opposite the mother's chair. The Fisher Price School house will be set up in the middle of the room, at least 5 feet from the door. Hang the Comings and Goings poster (see Figure 2) on the wall opposite the mother's chair. The Visit Coordinator will remove the other adult chair.

After the break the VC ushers the mother and child into the room and tells them: "During this next activity you both may do whatever you wish." The VC points out the Comings and Goings poster then hands the mother the following laminated "reminder" card (Card C): "At the knock, leave the room however you'd like. Come into the observation booth. Your child should stay in this room." Then the VC leaves the playroom and waits in the observation room. After 3 minutes, the VC makes one firm knock on the observation window, and the mother leaves and joins the VC in the observation room.

Once in the observation room you can give the mother more instructions. Prior to reentering the room each time the mother should be told, "You can go back now and do whatever feels comfortable."

It is best if the VC memorizes the text on the card that was shown the mother during Solitary Play, and takes further instructions from there. If the mother asks questions, try to answer from the card. If there are no explicit answers to the mother's questions on this card, tell the mother she can handle the situation as she sees best. Be careful, however, no to over-emphasize that the mom should stay in her chair. We'd like her to be there but we also want her to be free to respond to the child. If she presses you on this, say, "We'd like you to stay in your chair whenever possible, but it's up to you to determine when that is."

What to do if the mother cannot leave

Sometimes the child becomes very distressed when the mother tries to leave. Give the mother 30 seconds to one minute to try to leave on her own. The length of time depends on your judgment of the child's distress. We want you to intervene after the child is upset, but before the child gets highly upset. Most important, we want you to intervene before the child gets out of the playroom in an attempt to follow the mother. Once the child is out of the playroom, it is often very difficult to get them to return! Thus, your decision will be based in part on how persistent the child is in following the mother or in leaving the room. If the child clings to the mother at the door, tries to get out the door with her, and otherwise shows that the separation is difficult, then someone (the VC or an assistant) should simply enter the room and say to the child, "I'll stay here while your mother talks to X in the next room." The mother should then try to leave. Usually this will work, and the mother will be able to leave. However, if the child remains upset after 15 more seconds, the VC or assistant should attempt to engage the child with the toys and otherwise make the child comfortable enough to accept the mother's departure. Get down on the floor, call the child's name, and invite the child to play. If this does not work, and the child still clings and cries and impedes mother's departure for another 30 seconds, then the VC or assistant should leave, saying to the mother, "That's OK, we will not have you leave now and we won't ask you to leave again today." Then tape the next 4 minutes of this "reunion" before going on to the next activity. Don't attempt any more separations. It is very important that the mother understands that you won't ask her to leave again.

Occasionally, the visit coordinator will be able to offer a hand to lead the child to the toys while the mother leaves. However, you should not physically restrain a child who is in full blown distress. If you reach the point where you feel only physically restraining the child will enable the mother to leave the playroom, then leave the playroom yourself, assuring the mother that there will be no more attempts.

Please note that the times indicated above for the different steps in this "distress at separation" procedure are approximate. You must use your judgment. Remember that once the child is distressed, the attachment system has been activated, and we can code what happens next, even if there has not been a real separation. Real separations according to our procedures are what we strive to accomplish, of course, but we also want to maintain rapport with the families.

The first separation lasts for 3 minutes, but if the child is crying, send the mother in after 30 seconds. If the child shows other signs of distress, such as wandering, calling, knocking on the door, it is not necessary to have the mother return unless the mother insists. If the child cries, however, the mother should return whether she requests to or not.

What to do if the child opens the door

One problem at this age is that the children are able to open the doors and leave. That's why we request that the VC stay posted at the door. If the child opens it the VC should be prepared to say , "Stay in the room and wait for your mother." Many children will stay in the room after this. If a child persists in opening the door, or actually leaves, the VC should return to the room with the child and sit in the chair. Don't be interactive, however, and after 30 seconds leave, saying, "I'm going to get your mom." Usually this is sufficient for the children to remain in the room for the entire separation. Try very hard not to have the VC in the room at reunion. It is imperative, however, that a reunion with the mother not occur in the hall where the camera can't record it, so in individual cases you must use your best judgement to get the best reunion possible.

The first reunion lasts for 3 minutes. It can be a minute longer if it takes the child longer to settle. However, if a child who had been highly distressed is not settled and returned to play after 4 minutes, don't bother doing the second separation. Instead, move on to Snack. However, don't abandon the second separation if the child is calm, not clinging, and is simply not playing.

The second separation lasts for 5 minutes. The same instructions for distress and child at the door given for the first separation should be followed here. After 5 minutes, the mother is cued to return. She should be told, "You can go back now and do whatever feels comfortable." The reunion lasts for 3 minutes. Make sure that it is not accidently shortened, as each minute here is crucial.

The moment of reunion is critical. As the mother enters, as soon as she would be visible to the child, quickly pass your hand in front of the lens to let the coders know that she has returned. Keep the camera focussed on the child at all times. Fill in the screen with the child, and don't pull back until/unless the child and mother are very close together. When in doubt, give us a good shot of the child without the mother, rather than sacrificing a good shot of the child to squeeze both mother and child in the frame. Remember, large expanses of wall and rug don't help coders, we want to see the child and then, only if possible, the mother too. Sometimes children try to leave even after mother returns. The VC should be ready to tell the child to stay in the playroom should the child start to leave.

What to do if the child announces he/she has to go to the bathroom just before the reunion.

If the child acts like she has to go to the bathroom during the time she is alone, send the mother in early. Ask the mother to try to stay in the playroom a few moments before going to the bathroom, but then let the mother decide what is the best course to take. If the child is desperate, the mother may know this and leave immediately. The result of her action will be missing data. So be it. It is more important that we handle the "potty dilemma" with sensitivity.

If the child asks where mother is.

Tell him/her that mother is in a near-by room doing some other work while the child is in the playroom. It is alright to assure child that mother will return after a while.

If a child becomes highly distressed during the Separation/Reunion and a second separation will not be attempted the Visit Coordinator should tell the mother prior to her reentering the playroom that she will not be asked to leave again.

At the end of the Separation/Reunion procedure Visit Coordinators should routinely reassure the child that the mother will not leave again.

For children who become distressed or agitated, VCs should make a sympathetic acknowledgement before proceeding to the Snack. VCs can say, "I hope that wasn't too hard for you," "Let's see if a snack will make you feel better" or anything else that is needed.

All Visit Coordinators should also study the Strange Situations manual from the 15 month visit. Similar rationales exist between the two procedures, for instance, in handling of distress and severe separation anxiety. If a VC did no conduct 15 month lab visits, then it would be useful to learn how they were done for background information to be used when a judgement is necessary.

II. CODING SEPARATION AND REUNION

The Separation and Reunion will be coded according to the guidelines set forth in Cassidy and Marvin with the McArthur Working Group on Attachment (1992). Details are in a separate Coding Manual.

Figure 1

Separation and Reunion Flow Chart

1.	Mother and child in playroom.	3 min.
	Knock. Mother leaves.	
2.	Child alone.	3 min.
3.	First reunion.	3 min.
	Knock. Mother leaves.	
4.	Child alone.	5 min.
5.	Second reunion.	3 min.

Figure 2

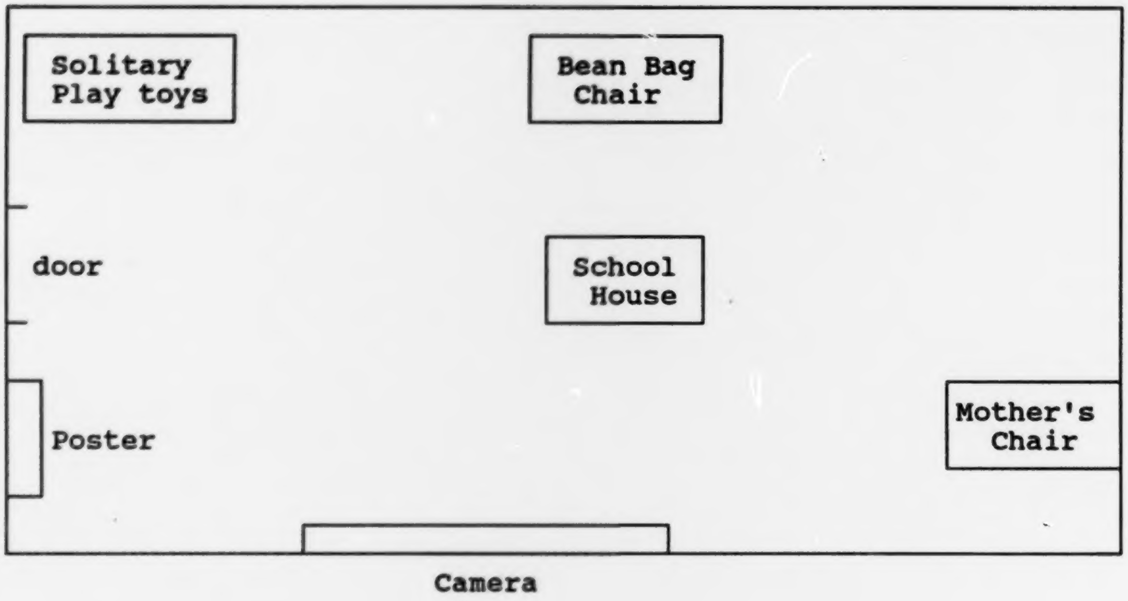
Comings and Goings

1. Child and Mother play.
2. Knock - Mother leaves, Child stays.
3. Mother returns.
4. Knock - Mother leaves, Child stays.
5. Mother returns.

How you leave, and what you do when you return, is up to you. Do whatever is comfortable.

Figure 3

Suggested Chair Placement for Separation and Reunion


Solitary
Play toys
Bean Bag
Chair
door
School
House
Poster
Mother's
Chair
Camera

Chapter 29

Section 4

SUB-MANUAL FOR SNACK

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Chapter 29

Section 4

SUB-MANUAL SNACK

I. PROCEDURES FOR BREAK AND SNACK

The purpose of the snack is to give the mother and child a break after the possible stress of the testing procedure. Although there are no current plans to code the snack segment, the informality and familiarity of the "task" provide good sources of information about mother-child language and quality of interaction.

Initial descriptions for this procedure were developed by Cathryn Booth. Revisions to the procedure were made by Deborah Vandell following comments and piloting by Temple, Pittsburgh, Washington, Wisconsin, and Western Carolina.

A. Materials

1. An adult-sized chair
2. A child size table
3. A child size chair
4. A plain tray containing:
   a. child-size cup
   b. cup for the mother
   c. Cheerios in a small Tupperware container

d. one individually wrapped slice of American cheese

e. snack sized box of raisins

f. several crackers in a small Tupperware container

g. napkins

h. medium size bottle of unsugared apple juice

i. baby wipes for cleanup

B. Procedures

When the visit coordinator enters the room, she should not bring the snack tray with her. Say to the mother, "Now it's time to take a break and have a snack. Would you and CHILD like to take a break and walk around or use the bathroom before the snack?" If yes, show them the direction to go. After about 5 minutes, ask them to return if they haven't already done so. When they have returned, or if they decide not to take a break, say "I'll go get the snack." When you re-enter the room say, "Why don't you and CHILD sit here. Here's the snack on this tray. Go ahead and have some yourself. I'll be back in 10 minutes." At some point, Visit Coordinator or mother should reassure child that the mother is not going to leave again.

After bringing the snack into the room, the visit coordinator should leave. The snack segment can continue until the mother and child have finished or for 10 minutes whichever comes first. Observe the snack from behind the one way glass. When it appears that the snack is finished, go in to the room and remove the remains of the snack. Move the table and chair to one side. If 10 minutes have elapsed, encourage the mother to "finish up" so that the visit does not become too long.

After snack, say "Please take CHILD to the bathroom now while I get the playroom ready for the next activity." If the child used the bathroom before snack, do not ask them to go again.

C. Videotaping

Although there are no current plans to code the snack as part of the common protocol, all sites should videotape the snack session. (See Videotaping Instructions in Section 29.1)

CHAPTER 29

Section 5

PROCEDURES FOR ADMINISTERING AND CODING THE REYNELL DEVELOPMENTAL LANGUAGE SCALES

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CHAPTER 29

Section 5

PROCEDURES FOR ADMINISTERING AND CODING THE REYNELL DEVELOPMENTAL LANGUAGE SCALES

I. OVERVIEW

The purpose of this procedure is to obtain an assessment of children's language development. The Reynell has two 67-item scales: Verbal Comprehension and Expressive Language. The Verbal Comprehension scale is a test of receptive language skills. Two separate, fully normed versions of this scale are provided to accommodate (a) simple oral responses--for use with normally developing children, and (b) pointing responses only--for use with children who have severe oral impairment (e.g., cerebral palsy).

II. MATERIALS

All the materials necessary to administer the Reynell are provided in the N-1 kit. Cost is $560.00 for one; two or more are $545.00. These include a test booklet and the stimulus materials presented during each section of the test. Reynell kits can be ordered from Western Psychological Services, 12031 Wilshire Blvd., Los Angeles, CA 90025.

Some sites have expressed concern about the ethnic homogeneity of the dolls in the Reynell. This test does not require that the stimulus materials be identical in all kits; as long as the 3-year-olds generally recognize what the materials are (e.g., a mother doll, a horse), they are acceptable. Thus, if you wish, you may purchase replacement dolls and match the dolls' ethnicity with that of each study child. Note, however, that the replacement dolls must approximate the original Reynell dolls in size, dress, etc. It will be impossible to find ethnically diverse milkmaids and hunters, so the dolls to be replaced just include the bendable people with felt clothes and the two small plastic babies.

If any test objects (other than the pictures) break, replace them with comparable store-bought items. Unfortunately, Western Psychological Services (WPS) does not have direct access to the supplier of these objects (they are in England). However, they would like to know about any breakages of objects, or objects that the children have difficulty recognizing. Please send a letter from your site detailing such problems to Chris Gruber at WPS in Los Angeles (see your test kit for the address).

III. SET-UP FOR THE PROCEDURE

Use a child-sized table and chair for the child. The VC should be seated at an adjacent side of the table in an adult-sized chair. Use an adult-sized chair to prop the Reynell Kit. Avoid distractions in the room. No other toys should be available to the child. Try to make the space small but comfortable.

Set a small adult-sized table and adult chair for the mother in the corner of the room. A magazine or two should be placed within her reach. DO NOT ask the mother to assist in Reynell administration as the WPS Reynell manual suggests; mothers are not the most objective testers and may (unintentionally or otherwise) give their children clues.

You and the child should sit near one another at adjacent sides of the child-sized table. Have the test case on the other side of you, out of the child's reach. This arrangement seems to work best for keeping the child involved, and makes it seem less like a test and more like a shared experience.

Close the test case between items; you do not want the child to be distracted by the other toys during the test. Do not have the toys in their plastic bags in the test kit. These bags are for shipping purposes only and should not be used. The plastic tray on top of the toys should keep most toys in their compartments. Be sure to check for the location of the smaller objects (i.e., buttons and knives) before the visit. They sometimes slip underneath the compartment tray.

IV. TEST ADMINISTRATION

The Reynell is administered immediately after snack (and a bathroom break, if needed). The VC tells the child, "Now you and I are going to play a game together." The mother is shown where to sit and given instructions for completing the CBCL and the Television Viewing Questionnaire. The VC and child should be seated and proceed with the Reynell.

Detailed instructions for administering and scoring the Reynell are found on pages 2-15 of the WPS Reynell Manual and in the accompanying Test Booklet. In this section, we add some general tips that expand on the original manual published by WPS. Please note that for the NICHD Study, we will NOT use the WPS Reynell Manual instructions for scoring the Content Section. Detailed instructions for coding this section can be found in Section VI.B.4 of this (NICHD) Manual.

Table 1 lists the items we will use for the NICHD Study. You should begin with Verbal Comprehension Sections 5 through 10A. Continue with Expressive Language (Structure, Vocabulary, and Content), making sure to administer the Optional Scene as well. There is no ceiling for the Reynell. You should attempt to administer all items listed in Table 1 to every child. A later section details instructions for administering lower items for children who fail all items in Section 5. The Reynell Test Booklet (page 8) gives age norms for test items. Because this test was designed for children up to 7 years of age, it is unlikely that many of the NICHD study children will pass all items. You should keep this in mind when administering test items.

Table 1. Reynell items used in the NICHD Study of Early Child Care

VERBAL COMPREHENSION

Section 5	Items 22-25
Section 6	Items 26-30
Section 7	Items 31-33, 35 **OMIT ITEM 34
Section 8A	Items 36-45
Section 9A	Items 46-59
Section 10A	Items 60-67

EXPRESSIVE LANGUAGE

Structure	Items 1-21, Optional Scene Items 1-4
Vocabulary	Pictures (Items 8-15), Words (Items 22)
Content	Items 1-4

Administer all items in the designated order. The Reynell was standardized using this order; thus it is important that you administer the items in this same order. If a child refuses to continue despite attempts to make it fun and interesting, take a break and come back. If a child still refuses to answer items from a particular section (or a particular item), then go on to a later item/section.

Make sure you have the child's attention for each item, before and while administering it. Establish eye contact with the child first. Say the words slowly and distinctly. This is particularly critical with the more complex questions, such as those contained in Sections 8A - 10A. Wait for the child to finish before asking the next question. Look for non-verbal cues, such as the child folding his/her arms or leaning back. If you're unsure whether the child is done, you can ask, "Are you done?", but try to use non-verbal cues when possible.

Avoid "over-repeating" questions; this could produce practice effects and/or may distract the child from the task. In some instances, however, it will be necessary to readminister an item; use the following guidelines in deciding whether you need to do so. First, if the child gives no response to a particular question at all, repeat it once. It is also appropriate to repeat the question when the child asks, "What?" By ensuring that you have the child's full attention before administering an item, however, the need to repeat questions will be drastically reduced. Finally, items should also be repeated when the child's response is ambiguous.

Make sure feedback to the child is uniform, regardless of whether the response is coded as a pass or fail (avoid saying "good" and other evaluative types of statements). Do not, however, provide feedback for everything the child does. Too much feedback slows down the pace of the test and can be annoying to the child. Alternatively, you can nod or smile at the child after a response. This does not mean you should never or rarely give verbal reinforcement; just use it less often, and use non-verbal reinforcement more often.

When the Reynell is completed, give the following instructions to the mother to introduce the self-control task:

> *"This activity is a waiting task for your child. It lasts about 5 minutes. During this time we'd like you to sit here and work on another questionnaire* (give mother the ASBI). *If your child asks you questions or wants your help, tell him/her, 'I'm busy right now.' Don't give your child any instructions about what to do."*

Show the mother Reminder Card D (taped to the table or clipboard) that contains the following:

Card D

> REMINDER: If your child seems to want your help during this task, remind him/her "I'm busy right now." Don't give your child any instructions about what to do.

V. RECORDING THE CHILD'S RESPONSES

Be sure to code each response as you go along. Always make a mark on the page for each item. Use a (\) to indicate a correct response and a (X) to indicate an incorrect response, written to the left of the item number in the margin. For the Vocabulary and Content sections in Expressive Language, write down what the child says verbatim as you hear it. The Reynell should be audiotaped or videotaped as a back-up for scoring spontaneous language in case you do not hear or understand what the child has said. In most cases, however, you will code child language live. If the tape is not needed for certification or coding other tasks, it can be erased and reused after coding.

The first section of Expressive Language involves being an astute listener to the child's spontaneous speech during both Snack and Reynell, and giving credit where credit is due. As for the last part of Expressive Language, you may or may not need to listen to the very end of the taped Reynell to be sure you don't under-credit the child. This would take five minutes. However, in most cases it will be quite clear from the first section of Expressive Language where the child's limits are (and therefore what to be listening for). Furthermore, most three-year-olds say very little in response to the pictures in the last section of the set (the Content Section), making it quite easy in most cases to write as the child speaks (especially with practice). Remember that the Reynell is used with children ranging from ages 1 to 7/8 years; our study children are in the lower half of the range, with limited capacity to respond creatively to the pictures.

Score all of the items not administered to the child (i.e., Sections 1-4, Item #34, and Objects) as passes. Note, however, that as described elsewhere in this manual, you will need to administer some of these items to a small number of children who initially fail all items in Section 5; for these children, score each item you administer as a pass or fail depending on the child's actual response. Any items that were refused by the child or inadvertently skipped by the tester should be left blank on the test booklet; they should NOT be scored as fails. Place an R (Refused) in the margin next to any refused items to indicate why they were not scored.

A Multi-Purpose Cover Sheet (Form DM-I) should accompany the completed Reynell test booklet. Do not total up the scores on the bottom of the test pages or on the cover; the Data Center will enter the data item by item and will generate a score for each child.

VI. INSTRUCTIONS FOR ADMINISTRATION AND SCORING OF SPECIFIC ITEMS

This section elaborates, clarifies, and in some cases changes the instructions given in the WPS Reynell Manual. It was developed in consultation with Christian Gruber, one of the test's authors, for use in the NICHD Study of Early Child Care. Whenever you see inconsistencies between the WPS manual and the NICHD manual, you should follow the instructions detailed in the NICHD manual.

A. Verbal Comprehension

Sections 1-4

Initially, you should score an automatic pass on all items in these sections for all children. The items in these sections are too simple for most of the 3-year-olds we will be testing; therefore we will only administer them to children who fail all items in Section 5. Part VII (this manual) gives instructions for administering the items in Sections 1-4 to this small number of children.

Section 5A

The WPS Reynell manual is unclear about whether the child must successfully complete the task in order to pass a given item. This issue is particularly relevant for **Item 22** ("Put the doll on the chair"). This is motorically difficult for many 3-year-olds. Section 5 is intended to assess whether children recognize the objects (e.g., doll and chair), not the prepositions. Therefore, the child must put the objects together in order to pass; the child does NOT need to successfully put one object on/in the other one. In order to reassure children frustrated with this task, you may help them make the doll sit on the chair once they have made an effort to do so themselves.

If the child places an additional object with the appropriate pair (e.g., for **Item 24**, "Put the knife on the plate," the child puts both the knife and the spoon on the plate), it should be coded as a fail. If you think the child did not hear the instructions, you may readminister once.

Section 7

When setting up for this section, objects should be placed in a row (beginning with the rabbit) to ensure that no relationship will be implied by their ordering.

Item 34 ("Which one shoots the rabbit?") should not be administered, and should be scored as a pass for all children.

Item 35 ("Who is carrying something?") measures whether the child can identify who is carrying something; therefore, it doesn't matter whether the child understands what a milkmaid or hunter is.

Section 8A

To ensure that test objects are in their proper locations before you administer each test item, complete each task for the child if he/she gives an incomplete or incorrect response. Do this unobtrusively, by saying something like, "Now it's my turn to move some toys...." This should shorten the administration time and should prevent testers from having to mull over the prompts on the score sheet.

When you ask "Give me the longest red pencil" **(Item 38)**, make sure you take it from the child when he/she offers it to you, then put it back with the others.

Due to limitations in their fine motor skills, some 3-year-olds may not be able to complete **Item 43** ("take two buttons out of the cup") without dumping all the buttons on the table. The item is asking that the child be able to understand the concepts of number and buttons. Thus, if a child dumps all the buttons out and then separates two, this should be scored as a pass because the child has demonstrated an understanding of the two central concepts. Similarly, if the child dumps three buttons out and then says, "Three," this too should be counted as a pass.

Item 44 ("Which pencils have been put away?") has caused some confusion for children, as they consider "put away" meaning away in the briefcase. In order to make sure the direction is clear for all children, you should ask **Items 44 and 45** as follows: "Which pencils have been put away in the box?" and "Which red pencil has not been put away in the box?"

Section 9A

The WPS Reynell manual does not elaborate on the set-up of the fence. The individual fence pieces snap together and should be placed in the shape of an incomplete square (two pieces on all sides but one). The side with one fence piece should be facing the child. Refer to page 10 of the WPS manual for a schematic.

Introduce this section to the child by gesturing to the field set-up and saying "Listen to what I am telling you: This is the field (point) and these are the animals (point)." Do not repeat the introduction later. For children who don't remember it, some will ask you to repeat the introduction while others will not. In order to avoid this problem, make sure you have the child's attention BEFORE you deliver the introduction. Use emphasis in your voice to ensure that the child is listening to you. If the child seems uncertain, or asks where the field is after you have introduced it, say something like, "Remember I told you where the field is, so think REALLY HARD. Do the best you can." Again, you can reassure the child that some parts are easy and some are a little harder.

As with Section 8A, to ensure that test objects are in their proper locations before you administer each test item, complete each task for the child if he/she gives an incomplete or incorrect response.

The word "behind" used in **Items 47** ("Put one of the pigs behind the man.") and **51** ("Put all the pigs behind the brown horse.") means that the pig(s) must be placed behind the other figure (man or horse) from either the figure's or the child's perspective in order to be scored as a pass.

The word "beside" in **Items 48** ("Put one of the small pigs beside the black pig.") and **56** ("Put one small pig beside the man.") means that the pig must be placed next to (not in front or in back of) the appropriate object (black pig or man) in order to be scored as a pass.

For **Item 53** ("Put all the pink pigs around the outside of the field."), the child must place the pigs on more than one side of the field. The child does NOT necessarily need to place the pigs on three or four sides of the field. The pigs should be broken up around the field and not clustered in one location.

Item 54 ("Put all the other animals and the man into the field.") should be changed to read "Put all the other animals into the field." The words "and the man" could confuse some children because at this point the man should already be in the field.

Item 58 ("Which pigs are furthest away from the man?") should read "farthest" rather than "furthest."

Make sure you have taken the box out before you proceed with **Item 59** ("Put all the animals except the black pig into the box.").

Section 10A

Before administering the items in Section 10A, linger over the introductions of Mother, Mary, Bobby, and Baby. Hand the figures to the child. Have the child say "hi" to each of them. Make sure the child knows who the four figures are before you begin to ask the questions. If the child or his/her sibling is named Mary or Bobby, use some other name for that figure.

For **Item 60** ("Bobby pushes the baby over. Who is bad?"), change the words "Who is bad?" to "Who did a bad thing?"

In **Item 61** ("Who does mother pick up and comfort?"), emphasize the words "pick up" rather than "comfort," which is a less familiar word for most 3-year-olds.

The items asking about school (**Items 62-67**) seem to confuse some children. When asked, "Who used to go to school but doesn't now?" (**Item 66**), one child named his sister, who was on summer break. Similarly, some children's mothers are in school, making it difficult for the child to understand and answer the question. When faced with a response such as this, the tester should say something like, "OK, that's in your family, but which of these people here on the table (point)...," in an effort to refocus the child. If the child is still unable to attend to the task within the context of the story, then the item is not passed. Remember that few 3-year-olds are expected to pass Item 66.

Some RAs have expressed concern about potential sex role stereotyping in **Item 63** ("Who goes shopping while Mary and Bobby are at school?"). While of course men, women, and children all go shopping from time to time, the task in this item is for the child to identify which of the four figures **displayed in this story** goes shopping when two of the figures are at school. Since there is no man among the figures in this scenario, mother (with or without baby) must be the one who goes shopping.

B. Expressive Language

The Expressive Language portion of the Reynell assesses three major components of child language: Structure, Vocabulary, and Content. Below are some general guidelines and grammar definitions that should be used in coding all segments of the Expressive Language, followed by detailed instructions for the administration and scoring of specific items.

1. General Instructions for Coding Expressive Language

Pronoun

A word that acts like a noun, but doesn't name a specific person, place, or thing.

Examples: I, you, he, she, it, we, they, me, my, mine, your(s), him, his, her(s), its, out(s), them, their(s), all, any, anyone, each, none, someone, somebody, everyone, everybody, who whose, whom, myself, oneself, this, these, that.

Preposition

A word that links a noun or pronoun to the rest of a sentence.

Examples: to, out, in, into, on, onto, with, without, by across, above, for, of, against, until, through, under, over.

Some of these words can also be used in contexts other than as preposition. Therefore, listen for these words in the context of a prepositional phrase. The preposition points out basic relationships between the noun/pronoun and the verb.

Examples: on the chair, by the white fence, behind the man, between two cups.

Past and Future Tenses

There are many forms of past and future tenses, but three-year-olds who use either are likely to use only the most simple forms.

Examples of past tense: he fell, the doll sat down, she put it here, I picked it up, they washed dishes, they got out of the rain, they got wet, the kids dug rocks.

Examples of future tense: he will fall, they'll [they will] eat now, the mommy's gonna say, "No, no, don't do that!", the boy is going to be afraid.

Mature Sentence Construction

Listen for true errors in the order or correct usage of words in the child's speech. Most children this age should fail this item. (Note: The usage of "gonna" is commonly accepted in oral speech.)

Examples of Mature Sentence Errors: Hers is standing up (instead of she is standing up); Where the pencil is?; My fix it; She going away.

Complex Sentences

Listen for sentences consisting of at least two separate verbs -- a principle clause and one or more subordinate clauses. Again, most children should fail this item.

Examples: They are angry because they got wet; I will sit down when I get the ball.

2. Structure

Language structure should be coded from the Snack and Reynell. The Optional Scene should be presented to elicit past and future tenses, complex sentences and immature speech, as these are not as common as other forms in a child's spontaneous language. The "Optional" Scene is required (not optional!) UNLESS the child has passed all items below Item 20, a situation that you will probably encounter only rarely. When you administer the Optional Scene, make sure no other toys are out.

Item 7 and below are automatically passed if Item 8 or higher is passed. Item 8 is passed if six definite items are heard or if expressive jargon/intonation is explicitly heard.

The following items within each set are related: if a child passes a higher item in a set, he/she automatically passes the items below that item in the set. Set 1: Items 9, 10, 11, 13; Set 2: Items 12, 15, 20; Set 3: Items 12, 15, 21.

"Appropriate use" in Items 16 and 17 means the words are appropriate when used; it does NOT mean that the child must use such a word when appropriate.

Record verbal examples of each item near the child's ceiling, typically around Items 16 and higher for most children. You should also record violations of Item 20 (Mature Sentence Construction).

3. Vocabulary

a. Objects

This section will only be administered to children who fail all items in Verbal Comprehension Sections 2 through 5. Part VII of this manual details the procedures to follow in this case. In the more common scenario, however, the Objects section will be skipped as the items are too easy for most 3-year-olds. Record automatic passes on all items in this section (Items 1-7) for these children.

b. Pictures

The WPS Reynell manual does not list examples of correct and incorrect responses for items in the Pictures section. The following list of passing and failing responses was compiled from actual children's responses reported from all ten Study sites. The list focuses on marginal non-standard answers; some answers are so obviously correct (or incorrect) that they have not been included. These decisions were made in accordance with Reynell rules and in consultation with Christian Gruber, one of the authors of the Reynell scales. Where possible, the underlying rule guiding the coding decision is described. The general rule to follow in deciding how to code a child's response is that if what the child says is something that is shown in the picture, the answer is correct. It should be a relatively salient feature of the picture, however, and not a minute detail. For example, "wall of bricks" is counted as a pass for Item #10 (window) because there is a large brick wall surrounding the window. By contrast, "stamps" is counted as a fail for Item #12 (letters) because the stamps are only a very small part of what is depicted in the picture.

Write down the child's responses to the pictures if they differ from standard responses. If the child gives a standard response (e.g., chair, flower, window, etc), do not write the child's response; simply score the response as a pass using the (/) nomenclature.

Item 8 Chair ("What is this?")

pass: seat

fail: table, a sit down

Item 9 Flower ("What is this?")

pass: plant, a particular type of flower, rose, sunflower

fail: garden, butterfly, tree

Item 10 Window ("What is this?")

pass: glass, curtains, wall, wall of bricks [they're in the picture and are very salient], building [it is pretty clear that the window is part of a building of some sort]

fail: house [the building is not necessarily a house], home, door, picture of a house, windshield, screen, kitchen, mirror, store, oven, snake, car, fireplace

Item 11 Drinking ("What is she doing?")

pass: drink, drinking milk, drinking a bottle, holding a cup, taking drink, taking some milk, drinking a cup

fail: milk, juice, bottle, girl eating cups, putting water on her face, scraping up the water, eating his milk, glass milk, eating baba, her sticking her chin up

Item 12 Letters ("What are these?")

The concept of plural or collective term must be demonstrated for this item to be scored a pass.

pass:	cards, postcards, notes, mail, envelopes, bills, papers, mails, mailmen things, messages, checks, tickets, mail things
fail:	card, paper, newspaper, pictures, mailbox, books, mailmans, post boxes, money, stamps, poster, pages, mailboxes, envelope, blocks, they're for you, crooked lines, puzzles

Item 13 Men ("What are these?")

Plural, age and gender must all be demonstrated; violation on any one of these dimension would constitute a fail.

pass:	people, guys, mans, daddies, papas, bad guys, friends, peoples, grandfathers, mailmans, dolls
fail:	man, kids, mommies, children, childrens, boys, trying to cross the street, my Dad, big kids, walking, dads and mommies, parent, Power Rangers, families

Item 14 Raining ("What is happening?")

Anything that "happens" in the picture is coded as a pass. Tense is important.

pass: rain, the rain, riding a bicycle, he's going on a bike, ride a bike, walking, crying, they're getting all wet, the man is following the dad, they are going, it starts to rain, rain's falling down, this boy cry, he's crying, she's getting wet, the rain drop, he hurt himself, he's coughing, they are sad, crying outside, riding, snowing, need a raincoat, she's hiding

fail: bike, umbrella, sick, man, he got hit (past tense), he hit his head, he got on the bike and fall, he buttoned his coat up, he's gonna fall down (future tense), that's a boy/ that's a lady/ that's an umbrella, bikes and the man there, this one's riding on the boat, the boy on the bike, somebody knocked her down, he fall down, her and him and him, get an umbrella, on a bike, the bridge is breaking, fall down the bike, fall off the bike, buy a bicycle

Item 15 Wet ("And the people are getting?")

Anything that the people in the picture are "getting" is coded as a pass.

pass: soaked, exercise, out of the rain, home or inside if the child said "going...", "walking" or "riding..." in Item 14, umbrellas or jackets if the child said "raining" in Item 14, rain on themselves, rained on, some rain, rain, cold, freezing, angry, mad, sad, sick, ready to go if child said "raining" in Item 14, in

[=inside], ready to go in the rain, out, away, ready/in trouble, they clothes wet, soaking

fail: riding bike, water, walking, raining, home or inside if the child said "raining in Item 14, umbrella or jacket if the child didn't say "raining" in Item 14 and was just labelling the umbrella/jacket in the picture, walking on the street, a bike, holding this umbrella, motorcycle, boy and bike, rained, raining, that's the boy riding his bike, water ice, money, something from the store, the bad guys, their bikes, it's raining on them, to school, washed up/they're going home

c. Words

Unlike the Pictures section, the WPS Reynell manual does give a few examples of correct and incorrect responses for items in the Words section. However, the list is limited and should by no means be thought of as an exhaustive list of possible correct answers. The following list of passing and failing responses was compiled from actual children's responses reported from all ten Study sites.

Item 16 Apple ("What is an apple?")

This item is used for practice, to ensure that the child understands the task. Therefore, FOR THIS FIRST ITEM ONLY, probe completely with all children (e.g., "What does it look like? What do you do with it?"), regardless of whether the child's initial response is a pass or fail. However, score the item based on the child's FIRST RESPONSE (i.e., before a follow-up probe), regardless of whether the child gives a "passing" response on subsequent probing.

Answers must clearly refer to what an apple looks like or to what you do with an apple, and they should be specific to apples (i.e., not too broad).

pass: eat it, eat, fruit, has seeds, for snack, peel it, has skin on it, with skin, you cut it with a knife, we crunch it, bite it, put it in your mouth, circle/cut it, has a stem/cut it, up in the tree, up to the tree/you grab it, food, apple is grow from trees and boys and girls eat them, off the tree, grows on a tree, like a plum [because the child says that it's LIKE another fruit, not that it IS that other fruit]

fail: round, red, green [these three responses are too broad- they apply to many things beyond apples], has a stick on it [this would have been a pass if the child had said it has a STEM (not STICK) on it], play with it, like juice, apple juice, cut it, cut it in half/put it in a bowl/put it on a plate, it's in the car/it's in the bag, apple tree/you throw it down, apple is on the street, put it in the 'fridgerator, put it on your head, a berry, plum, orange, the worms live in there

Item 17 Book ("What is a book?")

Many children's books consist of mostly pictures with few (or no) words. Answers in reference to a picture book therefore get credit.

pass: read it, writing, has pictures, pictures, pages in it, has drawings in it, telling stories, stories, you read stories, gots pages, for coloring, you color book, you look at word, can read/has some words, that you write on, for reading, writing words, I draw with those, you look at it, like what Mommy's reading, I turn the pages

fail: bunny book, thing what writes, got a picture book, rip it, a homework, paper, Berenstein Bears, library, picture, you open it, like a square, it reads, looking at, you hold, at home at my daddy's, out of his dresser, it's nice if you read a book

Item 18 Dress ("What is a dress?")

Passing responses include reference to a dress OR to getting dressed.

pass: put it on, wear it, clothes, skirt, get on and off, something you dance in, for my wear, you take it on/girls do it, put on the people, I wear, people put it on, to wear, it has flowers and pockets and a bow, mommy wears it, this clothes, clothes for girls, that's what you change into, get our clothes on, we have to wear it to a wedding, you swing around in it, to get all on the girl, it's when people put stuff on

fail: you get dressed, undress, for a girl, for girls, for dressing, dress yourself, we dress up, we get dressed, like the one I have at home, dress at home, color is pink, you get ready, it's in the drawers, you go to a wedding with a dress, go to work, you go to church, mommy's dress, you can tie the dress, get on, come from momma, for changing, ballerina, dress for take it off, beautiful, dancing, it's for a party, a white shirt, like mom's, in my tummy

Item 19 Sleeping ("What does sleeping mean?")

pass: going to bed, go to bed, sleep in the bed, going night-night, sleep on your pillow, don't wake up, nap, take a rest, like close your eyes, close the eyes, goes into blankets/into the pillow, going to night, lay down (sic), lie down, when you dream, go to dreamland, snore, time to go to bed, time for the bed, bedtime, get in bed, go night, lay down and resting, to get in your covers, dreaming, cover up, you put your body in your bed

fail: when you wake up, tired, in car, in nighttime, bed, go to sleep, wearing "jamas", night-night, good night, put on a pillow, I'm sleepy, it's dark outside, go to your room, we need to rest, go sleep, it's time to go to sleep, up to mama's bed, can't get up at 10 o'clock, it's dark, sleep with a pacifier, you brush your teeth, it's quiet, sleep tight/stars, yawn, say good night, baby, sleep turn off lights, it means that you're sick, get 'jammas on, take the skirt to bed, sit, chair, pajamas, sleep in the sleeping bag

Item 20 Loud ("What does loud mean?")

pass: shout, got a big voice, yell, all noisy, screaming, scream, holler, makes a noise, hurt my ears

fail: loud voice, echo, thunder, like a storm, we fight, hear your voice, scary, angry, wake up, mommy will give me a spanking, loud subway/dark and scary, boom, fire coming, a fire truck, singing loud, laughing, don't scream, it means you can't hear somebody, you get in trouble, baby does it, screamed "stop it", stop it, you get shot, barking, turn down the TV, wake everybody up, when you fall down, go to school, Daddy go work, mad, sleeptime, go to your room, be quiet

Item 21 Hungry ("What does hungry mean?")

The concepts of NEEDING FOOD or TIME TO EAT are important. It's not just food or eating. DO NOT count as correct anything that is a CONSEQUENCE of being hungry (e.g. go eat), unless it is the NEED for a consequence (e.g. you have to go eat, you need to get dinner). Count as correct anything that is a FEATURE of being hungry (e.g. tummy growling).

pass: wants food, waiting for dinner, starving, go to bed without supper, it's time to eat, can we please have food, time for you to eat, dinner time, give me some food, we need to eat, I want to eat, you want to have a snack, you can't eat, want some apples, he want to eat the cookie, you need to cook, tummy growls, need food, you have to eat, Pooh-Bear says rumbly in my tumbly when you're hungry, my belly is growling, time to eat breakfast, you didn't eat all the food

fail: eat, greedy, cook the food, eat at the table, go eat, eat dinner, I eat some food, eat food, come down and eat, he bite, food maybe, hungry is dinner, take all the food, tummy, bagels, you got to be and get hungry, food, in the kitchen, get food, get the people some food

Item 22 Cold ("What does cold mean?")

DO NOT count as correct anything that is a CONSEQUENCE of being cold or having a cold (e.g. go inside, getting medicine), unless it is the NEED for a consequence (e.g. you have to go inside, you have to take medicine). Count as correct anything that is a FEATURE of being cold or having a cold (e.g. freezing, coughing).

pass: freezing, you shiver, in 'frigerator, need a coat, we need to put a jacket on, want to get warm, you have to get a blanket on, frozen, chilly out, the flu, coughing, no going outside, put ice in it, you need to go to the doctor, you have to get in, when you're sick, shaking, freeze, freeze outside, that means it's in the winter when you get cold and it starts snowing, you have to go inside

fail: going outside, winter, wind, snow, snowing, get in house, cold from snow, ice cream, jack frost, brr, popsicle, freeze-pops, makes ice, water, rain, wet, raining, get warm, when it's raining, that you cover your mouth, hot, get water, in the car, freezing snow, give me jacket, get coat on, getting medicine, going to the doctor, go home, put your jacket on, you go inside, go in house

4. Content

The WPS Reynell manual included with the Reynell Test Kit contains many inconsistencies in the section on coding Content (p. 15-18). For that reason, we have developed the following guidelines for coding this section. **This NICHD manual is the ONLY SOURCE you should use in coding the Content section of the Reynell.** DO NOT refer to the WPS Reynell manual.

The aim of this section is to find out how well a child can use language creatively to describe a picture. All ideas must come from the child alone. Score statements that are meant to describe the picture. Do not score extraneous statements, such as "I like to help set the table." Responses are scored for the ideas, regardless of whether the statement is true. For example, "They're digging cookies" would be an acceptable response for scoring purposes, even though the picture shows potatoes (not cookies).

Administer the standard set of pictures; do not use the alternate pictures (laundry, toolshed). Make sure you have the child's interest and attention before you ask any questions. Put the pictures to the side of (not in front of) the child and look at them together; this will make it seem less like a test and more like a story. Introduce this segment with a statement like, "Let's look at this picture and see what it's about. What do you see in this picture?"

Picture #1 (Washing the Dishes) is used as a practice picture to ensure that the child understands the task; it is NOT scored. For this picture only, the RA should probe completely to encourage the child to give as elaborate of a response as possible. For example, in addition to asking the standard question ("What do you see in this picture"), ask the child follow-up questions such as, "What's the mommy doing? What's the girl (boy) doing?" Always write down verbatim what the child says in response to the practice picture; the child's response may be used for scoring the Structure section.

Since sentence boundaries in oral speech are less formally marked than those in written speech, it is important that auditory signs of completed thoughts (pauses, markers such as *um*) be noted at the time the verbatim record is made. To indicate discontinuities, write a slash (/) at the appropriate place in the test booklet during recording. Write down all that the child says verbatim, without editing or correcting any grammatical mistakes the child might make.

You may want to audiotape this section in case you are unable to accurately transcribe the child's language verbatim. Alternatively, you can always refer to the videotape when necessary. This will be very helpful when the child speaks quickly. Transcribe the child's expressive language verbatim, without editing or correcting inaccuracies in the child's speech.

a. Basals

Basal A and Basal B (the first two items for each picture, i.e., Items 1 and 2, 9 and 10, 17 and 18) simply indicate whether the child is responding to his or her perceptions of the actual events depicted in the pictures. Basal A is used to indicate that the child has made a statement about a specific feature of the picture (e.g., "There's a knife"), whereas Basal B indicates that the child has made a statement about the picture as a whole (e.g., "They are setting the table"). A child should NOT be penalized for perceptual inaccuracies. Basal A and B are scored independently for each picture. Hence, a child does not pass Basal A simply because he/she passed Basal B.

The following list should be used in determining whether a particular child statement qualifies as a Basal A or a Basal B:

Basal A:

- a specific feature of the picture
- a person or object (including proper nouns)
- a feature of the person or object
- a specific activity, not the major activity presented in the picture
  (e.g., "putting forks" or "digging potatoes")

Basal B:

- reference to a characteristic of the picture as a whole
- the major activity presented in the picture
  (e.g., "setting the table" or "gardening")
- description of the general setting
  (e.g., "outside" or "in the store")

No credit is given if the child repeats a word or statement either within or across pictures. This is true for both Basal A and Basal B. For example, if the child says "boy" in Picture #2 and again in Picture #3, no credit is given in Picture #3. However, if the child says "boy" in the practice picture (Picture #1) and again in Picture #2 (or 3 or 4), credit is given in Picture #2 because Picture #1 (the practice picture) is not scored, therefore the child has not yet received any credit for this response.

b. Idea Connections

The intent in scoring idea connections is to capture the distinct concepts that are used by 3-year-olds. While grammar is used to assist the coder in scoring idea connections, scoring is not tied to grammatical units. You should keep the following points in mind when scoring idea connections.

Score idea connections from the sentence with the most ideas. No additional credit is given for repeated words or phrases within this sentence. If a child gets credit for a higher idea connection item, such as Idea Connection C, he/she gets credit for Idea Connections A and B as well. Words that were scored as Basals for a given picture may also be scored as idea connections.

A sentence is defined as a single sequence of at least two interrelated ideas. Phrases connected by "and" or "but" are separate sentences. For example "He's digging the rocks and she's pulling weeds" are considered two sentences. If the child strings together a list of nouns (with or without using "and"), however, this is counted as one sentence. Phrases connected by words such as "when," "so," or "because" are considered one sentence. For example, "They're setting the table so they can eat the food" is one sentence.

In order to receive credit for an idea, the child must make reference to something depicted in the picture, AND the statement must be IN RELATION TO the picture. Thus, for example, in Picture #3 ("Shopping"), if the child says "I have umbrella," you would NOT count "umbrella" as an idea because the child's statement does not refer to the picture itself (even though it was inspired by the picture). "Umbrella" counts as an idea only if it is mentioned in reference to the picture. For example, if the child says, "There is an umbrella/I have an umbrella, too," you would give credit only for the first part of the sentence ("There is an umbrella"), but **not** for the second part ("I have an umbrella, too"). If the child had only said "I have an umbrella" and nothing else, he/she would receive **no** credit.

The following list should be used in determining whether a particular child statement qualifies as an "idea":

Ideas are:

* Nouns (i.e., a person, place, or thing).
* Proper nouns (Mary, Canada).
* Verbs (i.e., digging, setting).
* Adjectives (i.e., words that modify or add information to a noun, such as "blue sweater" or "big rocks"). Numbers, as in "four plates", are counted as ideas; however do not count **each** number if a child counts "one, two, three, four plates" as four separate ideas. The counting (one, two, three, four) is one idea.
* Adverbs (i.e., words that modify or add information to verbs, such as "quickly run" or "working hard". The adverbs "there" and "here," however, do not receive credit as ideas.

Ideas are not:

- Prepositions (i.e., in, on, into, between). These words may sometimes modify a verb like adverbs (e.g., picking up) but are never credited as ideas.
- Conjunctions (e.g., when, but, so) are not credited as ideas, but by connecting other ideas, they often contribute a great deal to a child's score.
- Non-specific placeholders (e.g., there, that, it's).
- Pronouns (e.g., he, she, they).
- Pronouns used as adjectives or adverbs (e.g., some, all, one, another).
- Possessive pronouns (e.g., his, her, my, your).
- Connective verbs (e.g., are, have, got) are not counted as separate ideas but are scored as part of one compound verb. For example, "are running" is one idea. Note, however, that the tenses of "have" (e.g., has, had, having) are not always used as connective verbs. If they are used alone, without another verb, (e.g., having a drink) they are counted as an idea. The tenses of "be" (e.g., are, is, am), however, are never credited as an idea because they don't add any information.
- Some word pairings are conceptual units to 3-year-olds and should be scored as one idea (e.g., "living room," "getting ready," "grocery store," "bunny rabbit," "all gone."

- Tenses (e.g., going to, gonna, did).
- Negatives (e.g., no, not).
- Articles (e.g., some, any, all, the, an).
- Parts of two-word verbs: pick UP, put DOWN, sit DOWN, put AWAY, ALL done, ALL gone.

c. Additional Sentences

Sentences are defined here as they were for Idea Connections. The sentences recorded here are in addition to the sentence coded in Idea Connection; thus repeated sentences do not count. Sentences are only considered repeated (and thus not given additional credit) when the words match exactly, NOT when the idea is the same in both sentences. For example, if a child says, "They go shopping"/"they go buy things"), you should give the child credit for both sentences because even though the two sentences express the same idea, the idea is expressed using different words.

VII. PROCEDURES TO FOLLOW WHEN THE CHILD FAILS ALL ITEMS IN VERBAL COMPREHENSION SECTION 5

Occasionally, testers will encounter children who do not pass any items in Section 5. When this occurs, the tester should proceed as follows.

Administer the items in Section 4. This section can be used as a warm-up (after Section 5), so the child is not frustrated from the beginning of the test. If the child passes any of the items in this section, proceed with the normal administration of the test.

If the child fails all of the items in Section 4, proceed with Sections 2 and 3. If the child passes any of the items in these sections, proceed with the normal administration of the test.

If the child fails all of the items in Sections 2 - 4, skip ahead to the Optional Scene (i.e., do not administer Verbal Comprehension Sections 6-10A). Then proceed with the Objects and Pictures sections of Vocabulary; SKIP the Words section. Finally, administer the Content section.

VIII. PROBLEM SOLVING

1. Child does not want to begin/complete the test.

It is essential to make a good effort to elicit the child's cooperation. Be upbeat and fun during the test. Be firm, yet friendly and engaging. Avoid "asking" the child if he/she will do the task. Promise the child a favorite toy for later in the lab.

Physical proximity and/or contact can be used quite successfully to regain a distracted child's attention; move closer to the child or offer a little contact if you think it might help. Try to pick up the pace, especially with difficult children. Do not wait too long after asking a question before moving on to the next item. You should only wait if the child is in the process of responding to an item. If the response is clearly wrong, move on.

If the child will not complete a section, move on and administer as much of the test as possible before the visit is over. Do not leave the testing room unless nothing else will work. If you do need to terminate the Reynell, try to complete it later in the visit if you think the child's behavior might improve.

2. **Child keeps getting out of her chair to look at the other toys in the kit.**

First, take all the extra toys that are not being used at the 36-month Reynell assessment out of the kit. Second, keep the box closed and only open it when you need to get out the next item. Finally, tell the child that you can only open the box if she is seated in her chair.

3. **Child repeatedly asks "this one?" when responding.**

Say something to the child like, "I want to see which one **you** think it is. Some parts of my game are easy and some parts are a little harder. It's OK if you're not sure-- just do the best you can." Repeat the question only once, but if the child keeps doing the same thing, stop and reinforce the concept that he/she needs to answer alone.

4. **VC cannot hear/understand the child's response.**

Ask the child to repeat the response more clearly and loudly. Do not ask the child to repeat his/her response more than once unless there is a clear reason to expect the child to communicate more clearly (e.g., the child was distracted and now is refocused, the child has removed hands from the mouth, etc.).

If you still do not understand what the child has said, listen to the tape immediately following the visit. If you can then completely understand the first response, WRITE AND CODE ONLY THE FIRST RESPONSE. If you can only completely understand the second response, WRITE AND CODE ONLY THE SECOND RESPONSE. If you cannot hear either response completely, WRITE AND CODE WHATEVER PORTION OF THE FIRST RESPONSE YOU CAN UNDERSTAND. Do not give credit for words you cannot understand; place a line (______) indicating the child said something you could not understand (e.g., "They're picking _________."). Although it appears that the child named a thing where the blank is, the child will not receive credit for a word you cannot understand.

5. Child is doing very poorly on the test.

Remember that there is NO CEILING for the Reynell; you should attempt to administer all items to all children. Keep going at a consistently good pace; don't wait too long between items. The child may surprise you if you keep the mood upbeat and be encouraging.

6. VC cannot complete the Reynell.

If the above tactics to elicit the child's cooperation fail, you should still treat whatever portion of the Reynell was completed as useable data. Send the incomplete Reynell test booklet to the Data Center as usual with the refused items/sections marked with an R (Refused) to indicate why they were not scored. DO NOT score refusals as fails.

CHAPTER 29

Section 6

SUB-MANUAL FOR SELF-CONTROL

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- C. Procedures 3
- D. Problem Solving 7

CHAPTER 29

Section 6

SUB-MANUAL FOR SELF-CONTROL

I. PROCEDURES FOR MEASURING CHILDREN'S SELF-CONTROL

A. Overview

The purpose of this videotaped assessment in the laboratory at 36 months is to obtain a measure of the child's self-control in a situation designed to minimize relationship-context confounds. Self-control will be measured from a task designed to assess the child's ability to delay and/or inhibit play with an attractive toy when asked by an experimenter to do so. After the Reynell is completed, the experimenter will produce an attractive toy. The toy selected for this task is exciting to preschoolers. The child's response to the experimenter's instructions to stop play and wait for a period before playing with the toy again will be coded.

B. Materials and Room Arrangement

"Ski Boat Crocs" by TOMY. (No. 1009)

A bag with a draw string to contain the toy initially.

A stop watch.

A flat-weave throw rug IF carpet in the lab room is plush and toy does not operate easily.

Clean-up basket with the toys from the Solitary Play session (minus the barn and silo). (no cover)

Magazine(s)

Reminder Card D

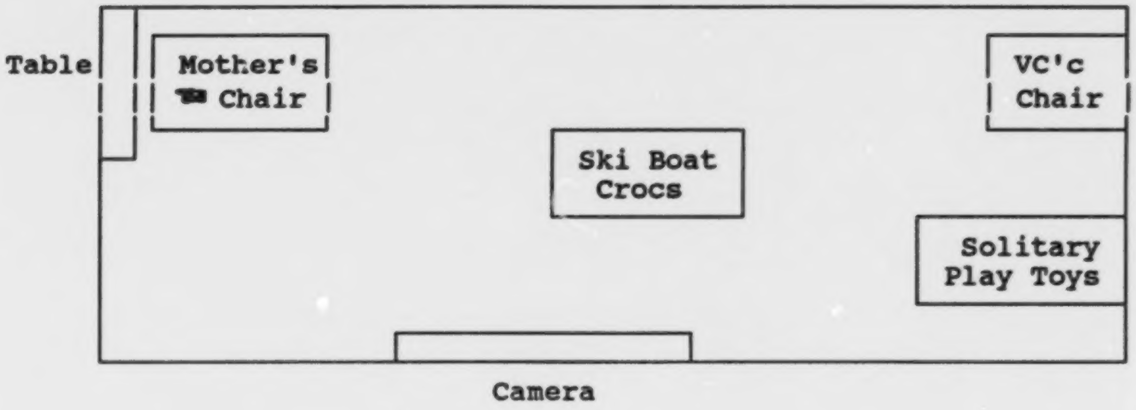
Adult-size chairs for mother and visit coordinator.

Small adult-size table for mother

The bin containing the solitary play toys will be stationed approximately 5 feet from the center of the room, ideally against a wall where they are out of the way, but visible and available to the child if he/she chooses to play with them during the imposed waiting period. No other toys are to be present in the room. The experimenter will not point out the solitary play toys' availability.

Place the mother's chair and the VC's chair in opposite corners on the far wall opposite the one-way mirrored glass (see Figure 1). This positioning will work best for our purposes. Individual lab rooms may not permit this exact placement. If the chairs cannot both be placed comfortably on the far wall, place them behind midline between the mirrored glass and the far wall on the side walls. The mother's chair should remain facing the small table as it did during the Reynell. This will allow the mother to use the table while completing the ASBI. An attractive magazine should remain within easy reach of the mother. The Reminder Card (Card D) should be easily visible.

Figure 1: Suggested Room Arrangement



C. Procedures

Following the Reynell be sure that the chair for mother is facing a small table as shown in the diagram. You should have given the following instructions to Mother prior to rearranging the room for the Self-Control Task (at end of Reynell):

> *"This activity is a waiting task for your child. It lasts about 5 minutes. During this time we'd like you to sit here and work on another questionnaire (ASBI). If your child asks you questions or wants your help tell him/her, "I'm busy right now." Don't give your child any instructions about what to do."*

Again, indicate the reminder card either taped to the table or clipboard that contains the following:

Card D

> **REMINDER:** If your child seems to want your help during this task, remind him/her "I'm busy right now." Don't give your child any instructions about what to do.

The Visit Coordinator should squat down next to the child, pull the toy out of the bag in which it was previously hidden, and indicate that she/he has a fun, new toy for the child to see. With excited anticipation, say:

> *"Look what I've got here. It's two crocodiles and their boat. Watch what they can do when I pull out the string. Are you ready?"*

Then demonstrate how the toy works so that the boat rolls from you to the child. After demonstrating once, ask the child to try making the crocodiles roll back to you, after which you should again send the boat back to the child, allowing the child one more turn and opportunity to have possession of the boat. This period of play should last no more than 1 minute. If the child will not play in the back-and-forth manner, do not insist but allow the child to handle the toy for 1 minute. The manner of play is not as important as the child's enjoyment of the toy during this period. The waiting trial is initiated by holding the toy then saying:

"I'm glad you like the crocodiles and their boat. We'll play with them again in a few minutes, but first I need to finish some work over here (indicate chair in the corner of room). You can play by yourself while I'm working, but don't touch the crocodile toy until I finish my work and I tell you we can play with it again."

Don't try to give the wait period instructions to the child while the child still has the toy in hand and is engrossed. The child doesn't attend well to your instructions if actively playing while the instructions are delivered. Wait until you have the "Crocs" in your hand before beginning the instructions. However, don't just take the toy out of the child's hands. Make the transition as natural as possible. Have the child send the crocs back to you or wait until "your turn" to get the crocs. This shouldn't add too much time to the initial play period and it helps ensure that the instructions are understood by the child.

When you put the toy down for the waiting period, try to place the crocs between the child and the camera. This will help predispose the child to turn to face the camera.

Sit in the corner of the room and do some "paper work." The toy is to be left on the floor, an arm's length from the child, who is not explicitly offered anything to do during the 2.5 minute wait. However, the solitary play toys (in a bin) are in the room, visible and available should the child wish to play with them during this time. If the child asks if he/she may play with those toys, say yes.

After giving the instructions not to touch the toy, the child is not given reminders not to touch. It is, therefore, extremely important that the child hears and understands the instructions. If the child appears not to understand or to have heard the instructions, the instructions should be repeated before the VC sits in the corner to do his/her "work."

Once seated, the waiting trial is timed for 2.5 minutes regardless of whether the child refrains from touching or touches and plays with the toy during this time.

The waiting trial is set for 2.5 minutes. Timing should begin as soon as the experimenter is seated to do his/her "work."

After the waiting trial, the child is allowed to play with the toy. Even if the child touches or plays with the crocodile toy, wait 2.5 minutes before terminating the trial. End the waiting trial by saying:

> *"I finished my work. We can play together some more now with the crocodiles."*

Join the child in the center of the room. When you resume play, remember to wait and see if the child picks up the croc after the waiting period. This helps assess the child's post wait interest in the toy. If the child does not, pick up the toy and hand it to the child. Then let the child play with the toy for 2 additional minutes, following the child's lead in letting him/her play alone with the toy or with you.

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D. **Problem Solving**

1. The child is unable to or doesn't want to play in a turn-taking fashion during the initial demonstration of the toy. Do not push hard on this. The point is to elicit the child's interest in the toy and to demonstrate how it works before requesting that the child wait before playing with it further. Allow the child to play with the toy after your initial demonstration in his/her own fashion, but deliver the toy after your initial demonstration instructions to initiate the waiting trial after no more than 1 minute of exposure to the toy.

2. If the child should become distressed during the waiting period, and the mother does not move to comfort the child, say "Feel free to try to comfort CHILD." The waiting period should be curtailed. You should offer the toy to the child, saying, "You can play with the toy now if you like." With the mothers present in the room during this procedure, distress is highly unlikely.

3. If, after instructions to the mother (and use of the reminder card), the mother does answer her child's questions with instructions, don't be overly concerned. The procedure is still codeable.

4. If the child spends the entire waiting period near mother (or even on her lap) do not intervene. If mother asks what she should do in this instance, you can remind her that she can tell her child that she is busy right now. If this is

awkward you can say that it's fine for her child to stay near her.

5. If the child asks questions of the VC during the waiting trial, answer as briefly as possible in a perfunctory manner that will not encourage additional questions and indicates that the VC is busy and not to be disturbed.

6. If the child expresses the need to go to the restroom, stop the procedure have the mother and take the child. When they return to the room, resume the procedure as follows:

If the break occurs during the initial toy play, prior to initiation of the waiting trial, then resume the procedure by giving the child an additional turn with the toy or approximately 30 seconds of lay with the toy, then initiate the waiting trial.

If the break occurs during the waiting trial, resume the waiting trial timing from the point that the break occurred, adding 30 seconds to the total time remaining. Initiate the resumption of the waiting trial by saying, "I still have some work to finish. You can still do whatever you wish while I work, but don't touch the crocodiles until I finish."

If the child tries to leave the room, say to the child, "Please stay in this room until we're finished. I'll tell you when you can leave." If necessary, physically lead the child back to the center of the room. If the child becomes distressed mother should comfort him/her.

ADDENDUM TO CHAPTER 29.7
PROCEDURES FOR ADMINISTERING THE THREE BOXES

Please do not replace the marker box from Box 1 (Red Box) with a Ziploc bag. We are developing a coding system for determining how mother's might mediate their child's cognitive development. This coding system looks at what the mother teaches the child. A mother who sees the markers in a Ziploc bag may start off on a lesson on how to open or close Ziploc bags, or alternatively, the child might ask the mother for help opening or closing the bag. It is best if everyone uses the same stimuli, and since the majority of sites started data collection with the markers in the marker box, it would be best to continue that way. Therefore the decision made at training has been modified.

As of April 1994, The Madison School Supply Store will no longer be carrying the Geobra Cash Registers. If you need to order a replacement please call The Village Toy Store in Delaware at 1-800-331-8697.

CHAPTER 29

Section 7

PROCEDURES FOR ADMINISTERING THREE BOXES

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CHAPTER 29

Section 7

PROCEDURES FOR ADMINISTERING THREE BOXES

I. OVERVIEW

The Three Boxes procedure during the 36-month lab visit is designed to assess the quality of mother-child interaction during a playtime. Videotaping this procedure will enable the interactions to be scored by coders who are "blind" to other information about the families. The rating scales to be used on these videotaped observations are similar to the Qualitative Rating Scales that are being used in the live ratings of the children's interactive experiences in child care. We are primarily interested in dyadic qualities and maternal affect, sensitivity, involvement, intrusiveness, and stimulation, and the child's affect, sociability, attentiveness, and activity level. It is recommended that lab staff review these scales. A basic familiarity with these qualitative scales prior to conducting the lab visit should provide some basis for on-the-spot decisions that might need to be made while videotaping the interaction. In addition, the task will be used to assess child compliance during ongoing interactions.

II. GENERAL INFORMATION AND GUIDELINES

The Three Boxes procedure follows the self-control procedure. The total time allocated is 15 min. Termination of taping before 15 min. should occur only when the mother explicitly requests it, or when the mother is resentful, angry, or hostile ABOUT THE TAPING. In these circumstances taping may be stopped earlier than 15 minutes, but a minimum of 10 minutes of taping are needed for codeable data. Throughout the episode it will be the camera person's job to capture the child and mother on videotape. Technical details on taping are supplied in Section 29.1.

III. MATERIALS

Toys are placed in three open boxes.

The principles underlying the selection of the three toys were that the toys should (a) be interesting to children of this age, (b) foster different types of activities, and (c) have the potential of being used differently by the children and their mothers. Mothers can attempt both age appropriate and inappropriate activities with each toy. Each toy is placed in a separate open box (dimensions approx. 17" by 9 1/2" by 12"). The box should be covered with solid colored contact paper. There should be a large, legible number drawn on the front box. The boxes should be placed on a table located at one side of the playroom.

The following toys should be in each of the three boxes. Each site should buy their own toys (except for the cape which will be provided by the North Carolina site.

BOX 1 (Red Box) This box should include an 8-marker box of Crayola Washable Markers, a tablet of white blank paper with a cardboard backing that should be at least as large as standard writing paper (11 x 8 1/2), and the outside portion of 4 stencils (Rabbit, Penguin, Dolphin, and Elephant) from Traceables - Living Things Stencil Set (Model #LR-2572) for $7.50. This can be order from Joe Lemp, Madison School Supply, 2219 Atwood Ave., Madison, WI 53704, phone (608)249-9787

Mothers can respond in a variety of ways to the materials in this box. Some may attempt to show the children how to use the stencils. Some may attempt a writing or drawing lesson. Some will follow the children's interest; others may follow their own agenda. These materials are also interesting because it allows us to see how mothers handle the transition if the children are not interested in the materials.

BOX 2 (Blue Box) This box should include the following dress up clothes: 1 pair of men's small size dress shoes, 1 pair of women's small pumps with a short heel, 1 flashy vest with glitter, gold, sequins, etc., 1 child size cape (the cape will be provided by North Carolina site). In addition, the box should contain the Geobra Cash Register which can be purchased for $12.00 plus $3.00 postage from Joe Lemp, Madison School Supply, 2219 Atwood Ave., Madison, WI 53704, phone (608)249-9787.

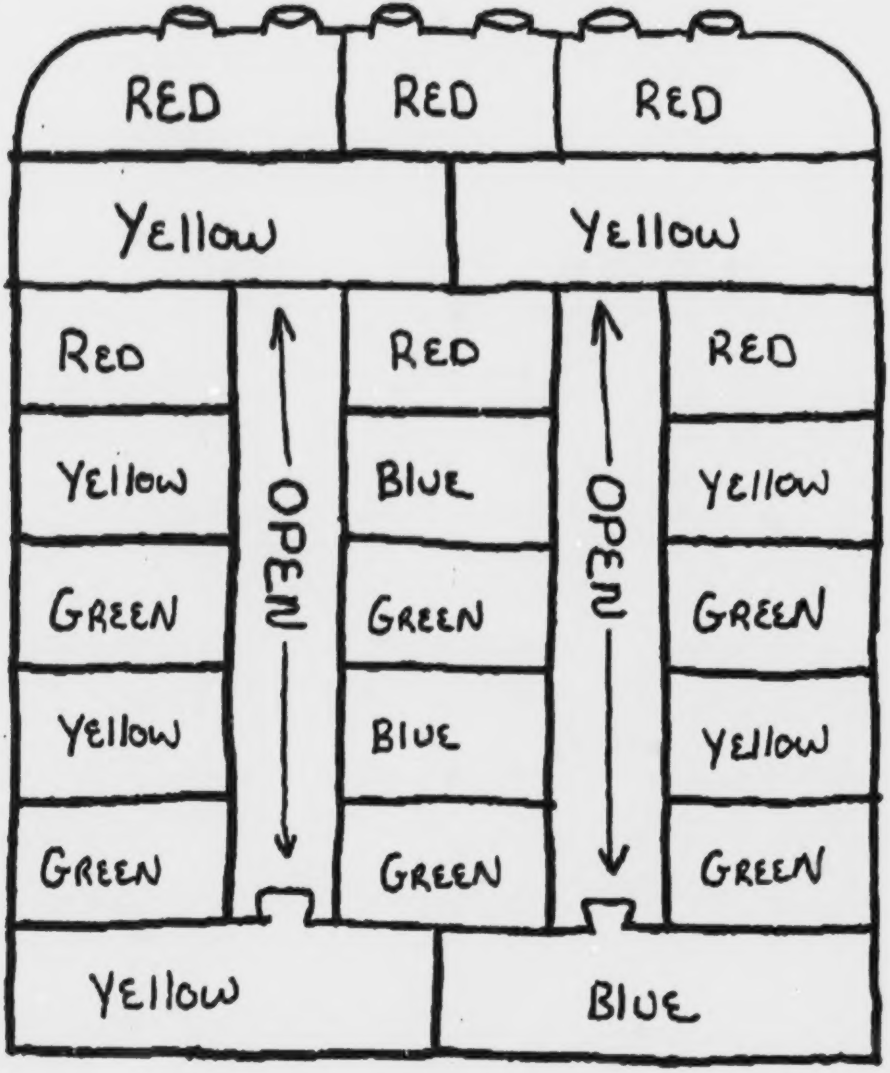
(Please remove the cash register tape form the cash register, since we do not want to order replacement tape). Finally, 8 shiny pennies should be placed inside the cash register drawer.

The materials in box 2 can be used in a variety of ways. Mothers and children can engage in pretend play together using a store theme, or the children can engage in solitary pretend play. Alternatively, these materials can also be used in manipulatives. Children (and mothers) can explore the operation of the cash register. They can examine the clothes.

BOX 3 (Green Box) This box should contain the Duplo Preschool Building Set - Model #2374. The Duplo blocks should be placed in the container they came in and placed in Box 3. Be sure that the Duplos are separated into individual blocks. Be sure to remove the brochure that comes with the Duplo blocks from the Duplo container. A laminated color picture of a constructed model made from the blocks should be placed on top of the Duplo container in Box 3. Figure 1 is a black and white copy of the color picture. Each site was provided with a color picture of the block model by the Wisconsin site.

The items in box 3 can be used as construction toys, but they also have the potential for pretend play. Mothers may participate with the children in this play, or they may not.

Figure 1: BLACK AND WHITE COPY OF THE CONSTRUCTED MODEL MADE FROM THE BLOCKS


RED
RED
RED
Yellow
Yellow
RED
RED
RED
Yellow
OPEN
Blue
OPEN
Yellow
GREEN
GREEN
GREEN
Yellow
Blue
Yellow
GREEN
GREEN
GREEN
Yellow
Blue

IV. ROOM ARRANGEMENT

The room should be arranged as shown in Figure 2. There should be a table on which the 3 boxes are placed in order. The table should be against the side wall in reference to the camera. The table should be high enough so that the child cannot reach up to the boxes. Place toys against wall on table so that they are difficult for child to reach. There should be a throw rug approximately 3 X 5 to 4 X 6, placed with longer side parallel to the one-way mirror, to mark the area where mother and child might be likely to play. There should be two office chairs and an end table with magazines so that the mother may chose to sit and read magazines while the child plays. There should be a clock on the same wall as the camera window so that if the mother wishes to keep track of how long they play with each box, she will be able to.

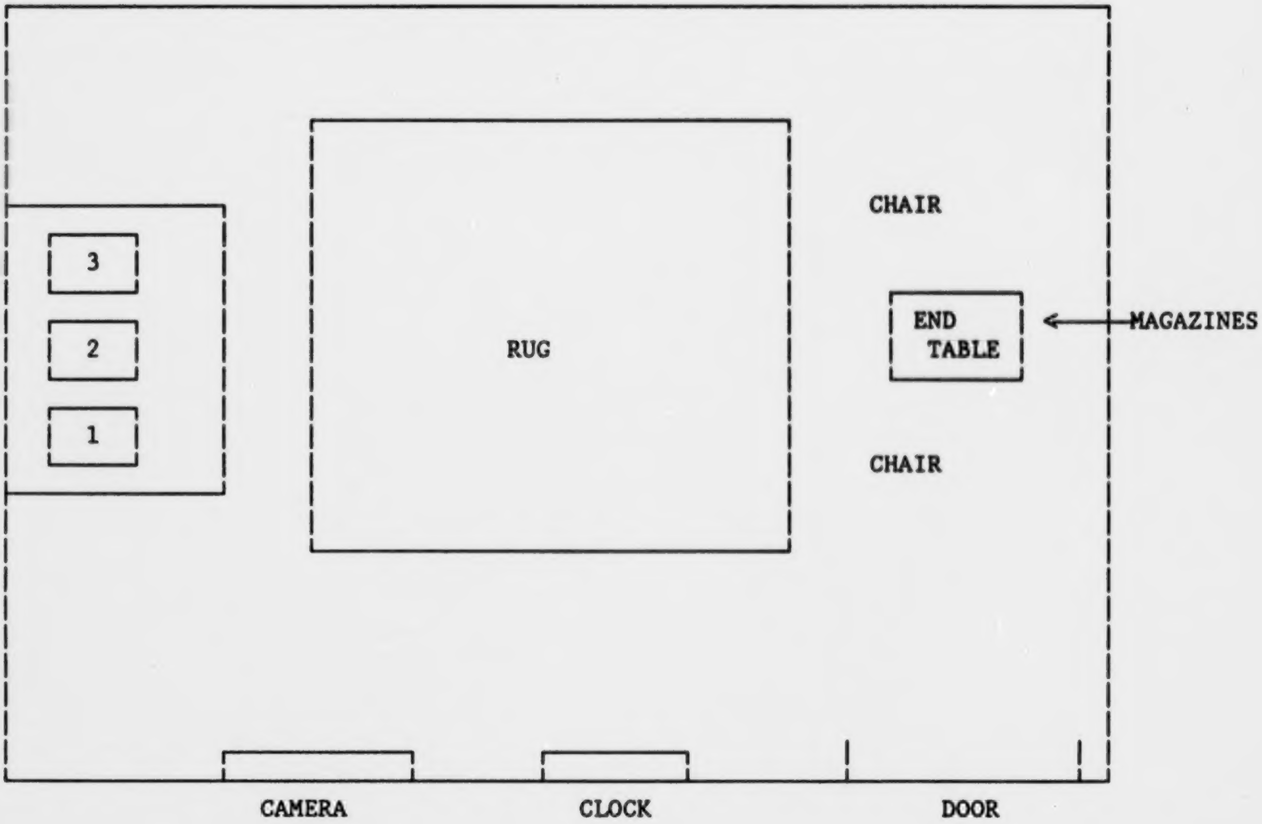

CHAIR
3
2
1
RUG
END TABLE
MAGAZINES
CHAIR
CAMERA
CLOCK
DOOR

Figure 2

V. INSTRUCTIONS

After completing the self-control procedure, the room should be rearranged for the Three Boxes. The two adult-size chairs that are already in the room should be used. An end-table for magazines and a high table for the boxes should be brought in. Place the throw rug on the floor. Put boxes on the high table, and the clock on the wall (see Figure 2).

Begin the Three Boxes procedure by saying:

"This activity will take about 15 minutes. Please help your child play with the items in the three boxes in the way you would at home if you were able to spend 15 minutes of free time alone with your child. Have CHILD start with the red box and finish with the green box. You can divide the time as you like. I need to remind you that we are filming through this glass window. If CHILD plays for a long period of time with his/her back to the window, I would like you to move him/her to a better place for our filming. Do you have any questions before we start?"

If mothers ask how long to spend on each toy, respond *"You can divide the time as you like."*

If a mother asks if she should do the red box first, confirm:

"We would like you to give CHILD the red box first."

If the mother asks if she should play with the child during this period, respond:

"Do whatever you might do at home if you were to help your child play with some new toys."

Note that you do not tell the mother how long the child must spend with each toy. Leaving the timing up to the mother allows us to see (a) how sensitive mothers are to their children's interests and needs without clear instructions from the experimenter, (b) if mothers appear either uninvolved or intrusive in the face of ambiguity, and (c) how mothers handle the transition from one toy to another. We can also focus on aspects of the children's behavior as reflected in the qualitative scales (e.g., positive and negative affect; sustained attention, activity, etc.).

If, during the interaction, the child plays for several minutes (2+) in a position in which his/her face cannot be filmed easily, and the mother makes no moves to reposition the child, the VC should go into the lab playroom and ask the mother if she would reposition the child for better filming.

Once 15 minutes are up, return to the lab room.

"That is all we need for that activity."

Continue with the PPVT.

VI. PROBLEM SOLVING

Any number of circumstances can arise which could potentially derail the successful implementation and completion of the videotaping of mother-child interaction. Listed below are several possible problems that might be encountered and their recommended solutions. It cannot be over-emphasized that it is impossible to anticipate all potential problems. You should thus maintain an attitude that permits "thinking on your feet" in order to confront challenges that might arise. Foremost to keep in mind are the needs of the mother and child and our desire to obtain high quality data.

Solutions that seriously discomfort families and breed resentment which could undermine further participation in the project must be avoided. At the same time, however, you must be prepared to work hard to find a solution that will enable you to obtain the data that are needed.

A. Video Malfunction

See Section 29.1.

B. Maternal Request

If the mother requests/demands to stop for any reason, approve automatically. Check if this is a request for a temporary break (likely) or a request not to do the procedure. More than likely the request stems from the child's desire to go to the restroom. Then terminate and restart for the final 5 minutes if you can. If less than 5 minutes has gone by, start the timing of the procedure over again when you resume. If more than 5 minutes has elapsed before the break in the procedure, resume the procedure and its timing where you left off. Note on the Videotaping log that the procedure was interrupted.

C. Maternal Refusal

If the mother says she does not want to do the videotape, remind her that other families have found it enjoyable, that parts of these tapes will be put together and given to her at the end of the study as a gift, and that no one other than research staff will view the tape. The goal here is to try to be "softly" persuasive. Empathize with her discomfort ("other mothers have felt that way"), but try to enlist her willingness. If you think that will put the mother off, go on to next phase of data collection and return to the possibility of videotaping once that phase is over.

Remember, all parents have been informed that they can refuse any part of study that they want to, so persuasion has to be "soft." If a mother refuses such efforts, respect her sentiments and be sure to point out not only that it is okay, but that we promised her in the beginning when she signed informed consent that she retained the right to any and all refusal. We don't want her feeling bad about letting us down.

VII. Training

The goal in training staff to the Three Boxes procedure is to insure that the tapes document mother-child interaction in a way that enables independent scorers to rate qualities of the interaction. Picture quality and sound quality must be excellent. Training on videotape technique using examples of what constitutes acceptable and not acceptable videotapes of mother-child interaction will occur during the network training session. Specific instructions will be sent to all sites in the spring of 1993.

VIII. APPENDICES

A. Videotaping Record Form

B. Videotaping Rating Form

CHAPTER 29

Section 8

PROCEDURES FOR ADMINISTERING PEABODY PICTURE VOCABULARY TEST-REVISED

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CHAPTER 29

Section 8

PROCEDURES FOR ADMINISTERING PEABODY PICTURE VOCABULARY TEST-REVISED

I. OVERVIEW

The manual for the Peabody Picture Vocabulary Test-Revised gives detailed information about the measure, its reliability, and its validity. We will be using the 1981 revised edition of the PPVT (form M). In this manual you will find special instructions that pertain to this study.

Each site needs to order the PPVT-R and forms from the American Guidance Service (612-786-4343). A kit containing the manual, plastic test plates, and 25 test forms costs $67.50. All mothers should be given the English language version.

II. MATERIALS AND PREPARATION

A. Preparation

You will need the Examiner's Manual, the stimulus pictures, and a record form (form M).

Record the child's ID number, not the name of the mother, where requested. Record Date and mother's date of birth where requested (see box on form). Record the examiner's ID number, not the name of the examiner, where requested.

III. PROCEDURE

A. When to administer the test.

The PPVT-R is administered after the Three Boxes. Another examiner should keep the child occupied while the test is administered to the mother. Before beginning the PPVT-R the mother should be offered some refreshments. The child can also be given a small snack at this time.

B. Introduction of the procedures

Introduce the PPVT-R as follows:

"We have a vocabulary measure for you to complete. Let me explain why we'd like you to do this. As you are well aware, we've collected a lot of information about CHILD, you and your family over the last three years. One of the things we're observing for CHILD is vocabulary development. It will be helpful to know about the words you know so we can see whether children's vocabularies are related to their mother's word knowledge.

The vocabulary measure is a straight- forward measure. I will show you a series of pages, each with four pictures on them. For each page I will say a word and you will tell me the number of the picture which best tells the meaning of the word. The words will start out easy and will get more difficult. You are not expected to get every word right. Guessing is fine; when you come to a word that you are not sure of, just make your best guess.

I hope you find this interesting after seeing us do so many things with your child. Let's do a few practice words."

If a mother's primary language is not English, explain that we are interested in her English vocabulary because we are testing the child in English.

C. Administration

Administer training plate d; administer training plate e. Ask Mother if she has any questions.

1. Where to begin

Begin the test with plate 110. The manual states that you should start at a lower point for subject suspected of being below the 25th percentile in Standard English hearing vocabulary (see p.7). Use your best judgment. Where you begin is not really critical, because you are allowed to go backwards and forwards to obtain a basal and ceiling. However, try to be sensitive to the feelings of the mother. Since we say the words will start off easy, they should start off easy. You and your PC may want to decide where to begin the test based on your knowledge of the mother.

2. Giving the test

Follow the administration procedures in the manual. Pay particular attention to the section on basal and ceiling rules (pp. 8-13). Give training plates d and e. Ask if she has questions. For the first picture say, "Tell me the number of the picture which best tells the meaning of _____." For the second picture plate ask, "Now, what number is _____?" continue administering, using these phrases only as needed to remind mother of the instructions. For #162 (bovine) and #168 (laciniate) provide both pronunciations of the words to the mother. Scoring will be done by the Data Coordinating Center.

VI. PROBLEMATIC ISSUES

A. Mother asks you to spell the word.

This is not allowed (page 17 of the manual). Tell the mother: "I can spell the word only after the test is over."

B. Mother asks if that was the right answer.

As the manual suggests, tell the mother that the correct answers cannot be given until the end of the test. Give her the answers then if she asks.

C. Mother requests that the stimulus word be repeated.

This is acceptable according to the manual (page 17).

D. Mother takes more than 1 minute to answer.

The manual suggests (page 18) that after a minute's time, the examiner encourage an answer by saying "Make your best guess. Say the number you think is correct."

E. Mother asks to change her answer on a previous word.

It is acceptable for mother to change her answer to the current word or to any of the words that have already been done. (Manual page 18).

F. Mother asks if this is an IQ test.

Say that the test measures vocabulary, but that most psychologists wouldn't label this as an IQ test.

G. Mother asks how many she got wrong.

Explain to the mother that the test is administered until a person gets 6 out of 8 wrong. Remind her that the words are supposed to get more difficult. Tell the mother that the number that she got wrong is not really important. By saying this, we will be giving mothers very accurate information about the test.

If the mother persists: Say that she might want to contact the site coordinator.

Although it is fine to provide mothers with feedback on one or two vocabulary items if they ask, we should make every effort to avoid giving too much feedback because mothers can't really interpret this feedback (e.g. They may think 12 wrong is too many when it really is not.)

It is also important for us to honor the notice to users of the PPVT that the American Guidance Service displays on the front page of the form. "The PPVT-R is not intended for use in situations where truth-in-testing legislation stipulated that copies of the test items and correct answers be distributed to subject, parents, or the general public. Such disclosure may make the norms meaningless in future testing."

Give the mother the information, but explain that only the site coordinator can interpret the score and give the number meaning. Encourage her to talk with the site coordinator if she has questions.

H. Mother asks for feedback or expresses discomfort about her performance.

Continue to reassure her that no one knows all of the words. You can say something like, "It's hard to believe that someone could make a picture test of such difficult words."

If she wants feedback after completing the test, follow same procedure as for feedback about child's performance. Tell her that the test must be scored, and that you are not able to give her immediate information about her performance. Offer to have your PI or PC discuss with her by phone at a later time.

I. Mother asks which items she got wrong.

Tell the mother that you are not supposed to provide that information. Remind her that she can speak with the Site Coordinator if she has questions.

J. The PPVT must be interrupted.

Once the mother is ready to resume the PPVT, say "Are you ready to continue? Remember that I will say a word. You need to give me the number of the picture that best tells the meaning of the word. Any questions?"

K. What to do if you have to stop the PPVT and cannot resume it.

The PPVT can be given in the home in a separate visit by the visit coordinator. Review the instructions with the mother and begin at the point where you left off.

IV. TRAINING AND CERTIFICATION OF TESTERS

To prepare to give the PPVT-R, the examiners should follow these steps:

A. Read the manual several times.

Part 1 gives general information about the test administration and scoring. Of importance to us are: Test Setting (page 5): Establishing Rapport (page 6); Critical Range Testing (pages 7-13); Introducing the Test and Using the Training Plates (pages 13-16); and Rules for Item Administration (pages 16-19). Make sure that you practice reciting any unfamiliar stimulus words. On pages 129-134 are guides to pronunciation of the words.

Part 2 contains the specifics of the test construction, standardization, and norm development. Technical data and information on the reliability and validity of the PPVT-R are found in Part 3.

B. Administer a minimum of five practice PPVT-Rs with adult women.

C. The training will take place at the 36 Month Lab Training in Seattle in September 1993. Examiners should bring their questions to the training.

D. After the training, examiners will videotape themselves administering the PPVT-R to two women. These tapes will be sent to the UNH site. Based on these tapes, an examiner will be judged by trained personnel at UNH as either certified or not certified. Examiners who are not certified will be given appropriate feedback and asked to send additional tapes.

CHAPTER 29

Section 9

PROCEDURES FOR TELEVISION VIEWING QUESTIONNAIRE

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CHAPTER 29

Section 9

PROCEDURES FOR TELEVISION VIEWING QUESTIONNAIRE

I. OVERVIEW

The purpose of the Television Viewing Questionnaire is to get an estimate of the time the child spends with television. "Watching" television is defined as being present and awake in the same room with an operating television set. Although we know children are not always viewing, parents can report the time children are present and awake much more accurately than the time the child actually attends to the screen.

"Television" includes programs and movies received over the air, by cable, and on videotape. It does not include videogames like Nintendo.

The questionnaire asks the mother about the child's exposure on four days: Saturday, Sunday, Tuesday, and Wednesday. The mother's answers will be in quarter hours.

II. MATERIALS

Television Viewing Questionnaire

Writing Board

Pencil

Reminder Card D

III. PROCEDURE

The Television Viewing Questionnaire is completed by the mother immediately following the CBCL, while the VC and child finish the Reynell. The questionnaire should be handed to the mother with the CBCL before beginning the Reynell. The mother should complete the questionnaire while seated by the small table (see Chapter 29.5, III for room arrangement), as she did for the CBCL.

Before beginning the Reynell and after the CBCL instructions have been given, the VC should tell the mother, "The second questionnaire asks about your child's television viewing. Please read the instructions at the top of the form before you begin. Do you have any questions?" If the mother is unable to complete the questionnaire before the VC finishes the Reynell, she should complete it during Self-Control, before starting the ASBI. Before the end of the lab visit the Visit Coordinator will check over the mother's responses to make sure she has answered all appropriate questions and that she has not given discrepant answers for the same time slot when providing information on public television program exposure versus overall exposure.

Introduction

During Solitary Play, it is important for the Interviewer to explain the television questionnaire and our interest in the child's exposure to television. This can be a very touchy subject with some mothers, therefore, it is the RA's responsibility to make every attempt to put the mother at ease. To ease parents' concerns the VC should make sure to discuss the known benefits for older children, such as learning letters, numbers and games.

Below is a suggested introductory script. Visit Coordinators should not read this script to the mother verbatim.

> Later, I will give you a questionnaire about television that I would like you to complete while CHILD and I play. We know a lot about the benefits television can provide for older children. It is known that television can teach 4 and 5 year olds, songs, letters, numbers and games. However, very little is known about children CHILD's age, so we are interested in finding out if children this age watch television, and if they do, what they like to watch.

IV. TROUBLE SHOOTING

Visit Coordinator can use the following procedures either during Solitary Play, before the Reynell or later in the visit, to handle unusual circumstances that arise in regard to the television viewing questionnaire.

Mother's response to a time slot on questions 14-25 are higher than her response for the same time slot on questions 1-12.

At some appropriate time during the lab visit, such as during Three Boxes, the Visit Coordinator should review the mother's responses to make sure she has not given discrepant answers to the same time slot of questions 1-12 and 14-25.

If the mother has accidentally indicated that the child is awake in the room when public television programs are on for more time than when the television in general is on the Visit Coordinator should resolve each discrepancy with the mother before the end of the visit.

The Visit Coordinator should be sympathetic about how difficult it is to give estimates, and then remind the mother of the two answers she gave, asking her to clear up the discrepancy. The mother's responses should be changed appropriately on the questionnaire form. Visit Coordinator should be aware that parents are often sensitive on the topic of television watching, so this should be handled gently.

Mother does not finish the television questionnaire during the Reynell procedure.

The mother should continue to work on the Television Viewing Questionnaire during the Self-Control procedure, if she was unable to complete it during the Reynell. The Self-Control procedure should not be delayed to allow mother to complete the television questionnaire. Instead, after rearranging the room for Self-Control, the Visit Coordinator should tell the mother that she should continue to work on the television questionnaire during the next activity (Self-Control). The VC should then hand the mother the ASBI and ask her to complete it after she completes the Television Viewing Questionnaire. The remainder of the ASBI procedures should then be followed (see Chapter 29.10 for details).

Mother requests more information about the public television programs, such as on what channel or at what time they are broadcast.

The VC should sympathize with the mother about how difficult it is to answer some of these questions, then add that since we want all mothers to have the same information we can not offer further help other than the names of the programs. Encourage the mother to make the best estimate she can.

Mother indicates that her child watches other educational or public television programs for children.

Ask the mother to include only the programs on the list in her estimates for questions 14-25.

Mother responds using hours rather than letters from the response card.

The Visit Coordinator should recode the mother's responses onto a new questionnaire form following the visit. Another RA should then check the form to make sure the data have been coded correctly. Only the form with the letter responses should be sent to the DCC.

Mother is not usually with Child during some time slots.

If the mother is typically away from the child during some parts of those days, but is quite sure she knows about viewing in her absence she should indicate her answer by choosing the letter that indicates the number of hours. If the mother is uncertain she should indicate Z for "Don't know".

Family does not have a television.

The VC should explain to the mother that we are interested in how much time her child spends around a television, so she can include regular television exposure outside the home in her estimates (such as at a friend's home or in daycare). Tell the mother that all mothers are asked the same questions exactly as they are worded. Even though all questions may not apply to her family's situation, we need to have every mother answer the same set of questions. The VC should then encourage the mother to complete the questions as best she can.

Mother is unable to complete questionnaire during the lab visit.

If the mother is unable to complete the questionnaire during the lab visit, and the family will be returning for a second visit to complete other procedures, the mother should complete a new questionnaire at the second visit. If the family is not returning to the lab the mother should be given a blank questionnaire in a self-addressed stamped envelope and asked to return the completed questionnaire by mail within a week. Alternately, the completed questionnaire can be picked up at the home.

V. APPENDIX

A. Television Viewing Questionnaire - Form 38V

TELEVISION VIEWING QUESTIONNAIRE

CHILD'S ID NUMBER **REL**

0	0	0	0	0	0	0
1	1	1	1	1	1	1
2	2	2	2	2	2	2
3	3	3	3	3	3	3
4	4	4	4	4	4	4
5	5	5	5	5	5	5
6	6	6	6	6	6	6
7	7	7	7	7	7	7
8	8	8	8	8	8	8
9	9	9	9	9	9	9

DATE

Month		Day		Year 199__
0	0	0	0	0
1	1	1	1	1
	2	2	2	2
	3	3	3	3
	4		4	4
	5		5	5
	6		6	6
	7		7	7
	8		8	8
	9		9	9

INTERVIEWER/OBSERVER ID

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

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TELEVISION VIEWING QUESTIONNAIRE

The following questions ask you about the amount of time your child spends around television. We will define "watching television" as being awake in the room when the television is on because children this age often watch for only short periods of time. Please include both broadcast and cable television, as well as videos, in your estimates. For each time slot on this page, please indicate the letter that corresponds to your answer from the choices at the right.

At this time of year, how much time is your child awake in the room with the television on during a typical:

WRITE THE LETTER FROM THE LIST TO THE RIGHT.

1. Saturday morning (6 a.m. - noon) ________
2. Saturday afternoon (noon - 6 p.m.) ________
3. Saturday evening (6 p.m. - midnight) ________
4. Sunday morning (6 a.m. - noon) ________
5. Sunday afternoon (noon - 6 p.m.) ________
6. Sunday evening (6 p.m. - midnight) ________
7. Tuesday morning (6 a.m. - noon) ________
8. Tuesday afternoon (noon - 6 p.m.) ________
9. Tuesday evening (6 p.m. - midnight) ________
10. Wednesday morning (6 a.m. - noon) ________
11. Wednesday afternoon (noon - 6 p.m.) ________
12. Wednesday evening (6 p.m. - midnight) ________

A=0 hours
B=1/4 hour
C=1/2 hour
D=3/4 hour
E=1 hour
F=1 1/4 hours
G=1 1/2 hours
H=1 3/4 hours
I=2 hours
J=2 1/4 hours
K=2 1/2 hours
L=2 3/4 hours
M=3 hours
N=3 1/4 hours
O=3 1/2 hours
P=3 3/4 hours
Q=4 hours
R=4 1/4 hours
S=4 1/2 hours
T=4 3/4 hours
U=5 hours
V=5 1/4 hours
W=5 1/2 hours
X=5 3/4 hours
Y=6 hours
Z=Don't know

GO TO NEXT PAGE

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13. Does your child watch any of the following public television programs either on television or on videos?

Sesame Street
Barney and Friends
Mr. Roger's Neighborhood
Lamb Chop's Play Along
Shining Time Station
Reading Rainbow

0 NO (STOP HERE)
1 YES (CONTINUE)

If your child watches any of these public television programs, please give an estimate of how much time she/he is usually awake in the room while these programs are on. Again please include both television and videos of these programs in your estimates.

At this time of year, how much time is your child awake in the room while Sesame Street, Barney and Friends, Mr. Roger's Neighborhood, Lamb Chop's Play Along, Shining Time Station or Reading Rainbow is on, during a typical:

WRITE THE LETTER FROM THE LIST TO THE RIGHT.

14. Saturday morning (6 a.m. - noon) ________
15. Saturday afternoon (noon - 6 p.m.) ________
16. Saturday evening (6 p.m. - midnight) ________
17. Sunday morning (6 a.m. - noon) ________
18. Sunday afternoon (noon - 6 p.m.) ________
19. Sunday evening (6 p.m. - midnight) ________
20. Tuesday morning (6 a.m. - noon) ________
21. Tuesday afternoon (noon - 6 p.m.) ________
22. Tuesday evening (6 p.m. - midnight) ________
23. Wednesday morning (6 a.m. - noon) ________
24. Wednesday afternoon (noon - 6 p.m.) ________
25. Wednesday evening (6 p.m. - midnight) ________

A=0 hours
B=1/4 hour
C=1/2 hour
D=3/4 hour
E=1 hour
F=1 1/4 hours
G=1 1/2 hours
H=1 3/4 hours
I=2 hours
J=2 1/4 hours
K=2 1/2 hours
L=2 3/4 hours
M=3 hours
N=3 1/4 hours
O=3 1/2 hours
P=3 3/4 hours
Q=4 hours
R=4 1/4 hours
S=4 1/2 hours
T=4 3/4 hours
U=5 hours
V=5 1/4 hours
W=5 1/2 hours
X=5 3/4 hours
Y=6 hours
Z=Don't know

CHAPTER 29

Section 10

PROCEDURES FOR ADMINISTERING CHILDREN'S ADAPTIVE SOCIAL BEHAVIOR QUESTIONNAIRE AND CHILD BEHAVIOR CHECKLIST: 36-MONTH LABORATORY ASSESSMENT

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CHAPTER 29

Section 10

PROCEDURES FOR ADMINISTERING CHILDREN'S ADAPTIVE SOCIAL BEHAVIOR QUESTIONNAIRE AND CHILD BEHAVIOR CHECKLIST: 36-MONTH LABORATORY ASSESSMENT

CHILD BEHAVIOR CHECKLIST

I. OVERVIEW

The purpose of this assessment in the laboratory at 36-months is to obtain a parental rating of children's behavioral/emotional problems. Toward this end, each mother will complete the Achenbach Child Behavior Checklist For Ages 2-3 (CBCL\2-3). Mothers rate their child on each item that describes the child currently or within the last 2 months. The CBCL/2-3 consists of 99 items describing behavioral/emotional problems, plus an open-ended item for additional problems.

II. MATERIALS

CHILD BEHAVIOR CHECKLIST FOR AGES 2-3

Writing board

Pencil

Reminder Card D

III. PROCEDURE

Following the Snack (During the Reynell administration) the mother will be completing the CBCL. She should be seated by the small table (see Chapter 29.5, III for Room Arrangement). The Visit Coordinator should briefly remind the mother that during the next activity we would like her to remain uninvolved in what the Visit Coordinator and child are doing. The Visit Coordinator should indicate Card D to the mother.

The mother is then given a writing board containing the CBCL and a pencil. The following directions are read to the mother:

> *"Here is a list of items that describe children. Please fill out this form to reflect how your child behaves now or has behaved in the last two months. Please answer all items as well as you can, even if some do not seem to apply to your child. Feel free to write additional comments in the space provided on page 2. Please read the instructions at the top of the form before you begin. Do you have any questions?"*

Once mother's questions are answered (if there are any), the Visit Coordinator should begin the Reynell while Mother completes the CBCL/2-3. If Mother asks for definitions of particular terms, tell her that you can't define the words differently than they are presented. Tell her to use her best judgement.

IV. SENDING DATA TO THE DATA COORDINATING CENTER

Complete a DM-I, Multipurpose Cover Sheet, and send with the completed CBCL form to the Data Coordinating Center. Write "mom" on the DM-I and CBCL to differentiate from the forms completed by the child care provider.

THE ADAPTIVE SOCIAL BEHAVIOR INVENTORY

I. OVERVIEW

The purpose of this assessment in the laboratory at 36-months is to obtain a parental rating of children's adaptive social behavior. Toward this end, each mother will complete the Adaptive Social Behavior Inventory (ASBI). Mothers rate their child on each item that describes the child. The ASBI consists of 30 items describing children's adaptive social behaviors.

II. MATERIALS

THE ADAPTIVE SOCIAL BEHAVIOR INVENTORY
Writing board
Pencils
Reminder Card D

III. PROCEDURE

Following the Reynell be sure that the chair for mother is facing a small table as shown in the diagram. You should give the following instructions to Mother prior to rearranging the room for the Self-Control Task (at end of Reynell):

> *"This activity is a waiting task for your child. It lasts about 5 minutes. During this time we'd like you to sit here and work on another questionnaire (ASBI). If your child asks you questions or wants your help tell him/her, "I'm busy right now." Don't give your child any instructions about what to do."*

Again, indicate the reminder card either taped to the table or clipboard that contains the following:

Card D

REMINDER: If your child seems to want your help during this task, remind him/her "I'm busy right now." Don't give your child any instructions about what to do.

After rearranging the room for the Self-Control task the Visit Coordinator should hand the mother the ASBI questionnaire.

The following directions are read to the mother:

> *"Here is a list of items that describe children. Please fill out this form to reflect how your child behaves. Please read the instructions at the top of the form before you begin. Do you have any questions?"*

Once any questions have been answered, the Visit Coordinator should conduct the Self-Control procedure while mother completes the ASBI.

IV. SENDING DATA TO THE DATA COORDINATING CENTER

Complete a DM-I, Multipurpose Cover Sheet, and send with the completed ASBI form to the Data Coordinating Center. Write "mom" on the DM-I and ASBI to differentiate from the forms completed by the child care provider.

ADDENDUM TO CHAPTER 29.11
OPERATIONS MANUAL: 36 MONTH GROWTH MEASURES

In order to clarify what was written in the manual (Chapter 29.11, p.11), please note that the set of compliance ratings are to cover behavior that occur starting with the request to get undressed and ending with the final growth measure.

CHAPTER 29

Section 11

OPERATIONS MANUAL: 36-MONTH GROWTH MEASURES

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Acknowledgement: This manual was prepared collaboratively by Drs. Sarah Friedman and Peter Scheidt with input from Karen Livesey and was based on a manual from the Infant Health and Development Project, provided by Dr. Robert Bradley.

CHAPTER 29

Section 11

OPERATIONS MANUAL: 36-MONTH GROWTH MEASURES

I. OVERVIEW

The manual includes information about the following:

- Rationale for measuring weight and height
- The procedure: timing, location, set-up and order
- Instructions to the mother
- Maintaining rapport with the child during the session
- Equipment and procedures for its calibration and repair
- Procedures for measuring weight
- Procedures for measuring height
- Procedures for rating compliance
- Form for equipment calibration
- Form for recording 36 month weight and height
- Training of visit coordinators

II. RATIONALE

Physical growth as measured by weight and height are essential indicators of health and nutritional status of young children. An appropriate rate of growth in both weight and height can serve as a rough indicator of physical well being and of adequate nutrition. An inappropriate rate of growth may suggest significant chronic disease. Consequently, growth measures are important dependent variables in this study of child development and are expected to be related to variations in the child rearing environments. More specifically, it is expected that in very poor quality rearing environments, children will be at risk for failure to thrive. Furthermore, differences among children in terms of growth parameters are expected to be related to the psychological outcomes of interest in the study. The patterns of interdependence between environment, growth, and psychological function will be investigated.

III. THE PROCEDURE: TIMING, LOCATION, SET-UP, AND ORDER

The procedure will take place at the end of the 36 month laboratory visit, following the administration of the Three Boxes Activity. The child and mother will be brought into a room with a scale and a yardstick for measuring height. The yardstick will be taped to the wall, preferably next to a door jam. The mother will be told that if she chooses to stand next to her child, she is welcome to do so. BECAUSE THIS PROCEDURE WELL ALSO BE USED TO ASSESS COMPLIANCE, THE MEASUREMENTS WILL BE TAKEN IN A STANDARD ORDER. HEIGHT WILL BE MEASURED FIRST FOLLOWED BY WEIGHT. To measure height, the child's shoes must by removed. After the height measurement, the child will be prepared for the weighing procedure. For that procedure, the child must undress (alone or with help) down to a tee shirt and underpants (or diaper).

IV. INSTRUCTIONS TO THE MOTHER

Following the administration of the Three Boxes Activity, the child and the mother will be told that we are measuring the weight and height of the child, so we can tell how big he or she has become. The equipment will be shown and the procedures for weighing and measuring height will be explained to both mother and child. The mother will be told that at the end of the procedure she will receive a card showing how much her child weighs and how tall he or she is. The mother will be told that she can either sit and relax or that she can stand to the side of the visit coordinator. It should be made clear that both options are fine, as far as the visit coordinator is concerned. The mother should not be encouraged to choose one plan of action (or inaction) over the other.

V. MAINTAINING RAPPORT WITH THE CHILD DURING THE SESSION

One of the challenges to performing anthropometry on the 36-month old child will be to accomplish the task accurately without producing a physical struggle, a crying child, or an embarrassed parent. The visit coordinator's general approach to the child can help gain his/her confidence and dispel his/her fears.

Since it will be necessary to have the child undressed down to tee shirt and underpants (or diaper) to obtain the weight, this can be done by the child him/herself while the visit coordinator makes pleasant conversation with the mother, by the child with the help of the mother or by the mother. The visit coordinator will record what articles of clothing the child was wearing when weighed. If the mother objects to having her child weighed in a tee shirt (or an equivalently light top) and underpants (or diaper), the visit coordinator will note this on the Weight and Length Measurement form. Pull-ups should be recorded on the Weight/Height form as "diaper".

Prior to performing any of the measurements, each step should be explained simply to the child, and could be demonstrated with the mother, older sibling (if available), or the Visit Coordinator as the person being measured. When offering explanations, it is suggested that the visit coordinator should be close to the child and at approximately the same head-level as the child. This position makes the visit coordinator less threatening and helps establish rapport. For some children, it is helpful to allow them to touch or handle the equipment in order to make them feel more comfortable with the measuring process.

It is strongly advised that the visit coordinator avoid asking the child for his/her permission to do the maneuvers, since the visit coordinator is planning to do them in any case. Rather, the visit coordinator will proceed patiently, pleasantly, but firmly, attempting to convey to the child that there is nothing to fear and that the visit coordinator fully expects the child's cooperation.

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VI. EQUIPMENT AND PROCEDURES FOR ITS CALIBRATION, REPAIR AND SANITATION

The equipment for measuring weight and height is the same at each of the ten research sites. The scale needs to be calibrated following the same procedures in each site.

Scales for measuring weight

The scale to be used in this study is the Detecto Physician's Scale Model #437, without a height rod. A drawing of the scale is shown in Appendix A as well as in the Assembly and Operating Instructions that each site received with the scale. Each scale is a two beam scale with freely sliding non-removable weights (or poises).

The calibration of the scale should be checked before beginning the 36 month assessment and every week thereafter to the end of the 36 month laboratory visits. Calibration will be done with a standard weight provided by NICHD. To calibrate, zero balance the scale as described below. Place the standard weight on the scale platform. Move the weight on the main beam away from zero until the indicator points just above the center. Gently move the weight on the fractional beam away from zero until the indicator is centered. It may be necessary to move this weight back and forth several times to center the indicator. The weight should register the actual weight of the standard plus or minus 4 oz. on the scale. Weights provided to the sites as standards were not identical. Below is the weight of the standard provided to each of the sites:

Site	Weight of the Standard
0. Arkansas	23.58 lbs
1. California	24.47 lbs
2. Kansas	24.47 lbs
3. New Hampshire/Wellesley	24.03 lbs
4. Pittsburgh	24.25 lbs
5. Temple	24.03 lbs
6. Virginia	24.47 lbs
7. Washington	24.03 lbs
8. Western Carolina Center	24.47 lbs
9. Wisconsin	24.91 lbs

Scale calibration should be checked by a site specific designated individual with the standard weight every week during the 36 month assessments. Since the scale used at 36 months is not as precise as the one used at 15 and 24 months, the weight of the standard needs to be rounded to the nearest .25 lbs. For the purposes of calibrating the scale the following is a list of the rounded standard's weight:

0. Arkansas	23.5 lbs
1. California	24.5 lbs
2. Kansas	24.5 lbs
3. New Hampshire/Wellesley	24.0 lbs
4. Pittsburgh	24.25 lbs
5. Temple	24.0 lbs
6. Virginia	24.5 lbs
7. Washington	24.0 lbs
8. Western Carolina Center	24.5 lbs
9. Wisconsin	25.0 lbs

If you find that your scale is not weighing the standard accurately (plus or minus 4 oz.), contact a local scale distributor to have the scale professionally calibrated. It is essential that scales at all sites are properly calibrated in order for the data obtained to be comparable. The Scale Calibration form (14H) will be used to record the weekly calibrations (see appendix). Form 14H is then sent to the Data Coordinating Center after 22 weeks of calibration.

The zero balance of the scale should be checked before the beginning of each laboratory visit by a designated individual. To check the balance, place the weights on each beam at the zero position. There should be nothing resting on the scale platform except when a cloth is used for the child's comfort. When the scale is in balance, the indicator at the right end of the beams will be pointing to the exact center of the space provided. If the scale is not in balance, adjust the balance ball screw. Generally, only a fine adjustment is necessary. The scale is balanced when the indicator points to the exact center of the space provided.

"Yardstick" and T-square for Measuring Height

Height at 36 months will be measured with a "yardstick" and a t-square. Each site is provided with a metal yardstick and a standard builder's t-square. Height is also the standard method of measurement for children this age.

The yardstick is to be taped to a wall, preferably next to a door jam. The bottom of the yardstick (starting with 0 inches) should be flat against the floor of the room and flush against the door jam, so that the yardstick and the floor are perpendicular to each other. The yardstick should be checked before every visit to ensure that it is securely attached to the wall and is positioned at a 90 degree angle to the floor. The t-square can be used to check that the yardstick is positioned vertically at a 90 degree angle to the floor. The t-square should be stored nearby so that it is accessible for the measurement procedure.

Sanitation

The scale should be wiped clean using soap and water after each child is measured.

VII. PROCEDURES FOR MEASURING WEIGHT

To measure weight, follow these steps:

1) The child should be asked and/or helped to undress down to tee shirt and underpants (or diapers). The visit coordinator should record whether the child was in underpants (or diaper). If mother objects to having the child undressed, weigh the child in the minimal clothing approved by the mother and record what clothing the child has on at the time of weighing.

2) The mother or the visit coordinator should explain to the child that we want to find out how big he/she is.

3) Set the weights on both beams to zero.

4) Ask the child to step up on the platform of the scale. Be sure that the child is standing in the center of the platform.

5) Move the weight on the main beam away from zero until the indicator points just above the center. Gently move the

weight on the fractional beam away from zero until the indicator is centered. It may be necessary to move this weight back and forth several times to center the indicator. Read weight to the last completed unit. The scale used at 36 months is less precise than that used at 15 and 24 months. The markings on the balance indicate .25 lbs rather than 1/8th lb on the infant scale. If the weight falls between the marks on the scale, do not try to determine what that weight should be (i.e., in between 1/4 and 1/2, so 3/8), ALWAYS ROUND UP to the next mark.

6) Repeat the weight, asking the child to step off the scale, re-checking the zero balance and asking the child to step back on each time.

7) If the second measurement differs from the first by more than 4 ounces, record these weights and obtain two more weights according to the above procedure.

8) Clean the platform of the scale after use.

VIII. PROCEDURES FOR MEASURING HEIGHT

To measure the child's height, follow these steps:

1) Tell the child that you are going to see how tall he/she is.

2) The child should be asked and/or helped to remove his/her shoes.

3) Ask the child to walk over to the yardstick. Tell him/her that you want him/her to turn around and back up to the wall so that his/her back is against the yardstick. Make sure

that his/her heels are both touching the yardstick/wall and that the child's head is against the yardstick. Ask the child to stand straight and tall.

4) When the child is in the correct position, place the t-square so that one arm is flat against the yardstick and the other arm is perpendicular to the yardstick and positioned several inches above the child's head. Slide the t-square down the yardstick so that the bottom side of it touches the top of the child's head. Be sure that the t-square is flat against the yardstick and resting lightly on the top of the child's head. Then ask the child to step away from the wall. As the child steps away from the wall hold the t-square securely against the yardstick.

If the child has a hair style which will add to the height, such as a ponytail, the mother should be asked to undo the hair in order to get an accurate measurement.

5) To read the height, look at the position where the bottom of the t-square meets the yardstick. Record the height to the last complete 1/8".

6) Obtain a second measure, verifying the proper position of the child as described above prior to each measurement.

7) If the second measurement differs from the first by more than 0.25 of an inch, record these heights and obtain two more height measurements according to the above procedure.

8) Wipe off the yardstick and the t-square with soap and water after measurement is completed.

IX. RATING OF COMPLIANCE FROM THE GROWTH PROCEDURE

a. The child's response to instructions associated with the growth procedure are rated by the VC administering the procedure. One set of ratings is made which describe the child's cooperativeness across the entire procedure beginning with the removal of shoes and including the height measurements, removal of other clothing, and the weight measurements. Three 5-point scales, Compliance, Assertive Noncompliance, and Defiant Noncompliance, are then rated. In addition, contextual features of potential influence on the child's behavior are rated: (1) the child's fearfulness of the situation, (2) the degree to which the mother participated in the procedure, and (3) the degree to which maternal assistance interfered with child cooperation.

All ratings are made as soon as possible following the completion of the growth procedure. If possible the ratings are made while the child is being dressed following the height measurement. Children's responses to the various parts of the procedure are sometimes quite different. For example, a child could initially refuse to have his shoes removed at the beginning of the procedure but subsequently cooperate readily with all remaining components of the procedure. In this example, taking all behavior into account, the child would be viewed as somewhat less than highly compliant.

b. Rating scales (adapted by Owen from rating scales used in the Clean Up Procedure at 24 months as drafted by Belsky, Brownell, Campbell, and Cohn and revised by Owen, Mulvihill, Ware, and Mason).

General Instructions

In assigning a rating, the coder may find it helpful to use a two-step decision making process. The first step is to ask, "Is this dimension 'characteristic' (4 or 5 rating), or 'not characteristic' (1 or 2 rating) of the child?" In the event that the dimension is neither characteristic nor uncharacteristic, a mid-range rating of 3 should be used. Once this decision is made the coder can make the finer distinction between the 4 and 5 ratings or between the 1 and 2 ratings. Definitions of points 1, 3, and 5 are provided.

Goals of ratings

During the preschool years children must establish their autonomy while learning to accommodate to the needs of others. The goal of the ratings is to capture the extent to which and manner in which the child cooperates with the adult's requirements in the growth procedure. The ratings describe the frequency and quality of the child's compliance and noncompliance to the adult's various requests in this procedure. Both compliance and noncompliance increase with age during the preschool years and both can be evidence of positive developmental change.

In using this rating scheme, the first task is to consider and rate how compliant/cooperative the child was. The child's cooperation with the tasks themselves is to be considered, whether directions or requests were made by the procedure administrator or the child's mother. Following the decision regarding child compliance/cooperation, the rater should next consider what form the child's lack of cooperation took and to what extent it was shown. We are making ratings of two specific forms of noncompliance, assertive noncompliance and defiant noncompliance. Thus, high ratings of either assertive or defiant noncompliance will be negatively correlated with ratings of compliance. Children may display both assertive and defiant noncompliant behavior during a part of the procedure. For example, a child may say, "no, I don't want to," when asked to take off her shoes. When pushed further to do so she may stomp her feet and angrily insist that she will not comply. The occurence of both assertive noncompliance and defiant noncompliance would be rated.

Some uncooperative/noncompliant behavior will occur that is not either assertive noncompliance or defiant noncompliance. For example, uncooperativeness may take the form of whining that is neither a competent assertion or an expression of angry defiance. The child may be simply tired and uncooperative but not overtly assertive or defiant. Children may also not comply immediately when they have not understood the direction or are distracted from the task. It is possible, therefore, for children who are uncooperative in the procedure but never assertive or defiant to receive 1's on all three rating scales.

Finally, it should be recognized that not all of the child's behaviors need to be viewed as compliant or noncompliant. For example, the child and mother may engage in interaction unrelated to the procedure that results in lengthening the time to complete the procedure but that is unrelated to cooperativeness with the procedure itself.

A. Rating Scales

1. Child compliance scales

a. Compliance

This scale captures the degree to which the child willingly follows or cooperates with adult requests during a particular phase of the procedure. It takes into account the ease with which the VC completes the part of the procedure being rated. Highest ratings are given to children who are highly cooperative and comply immediately to requests. For example, when asked to undress, the highly cooperative/compliant child proceeds to remove all his/her clothing without additional encouragement. Or, he/she may cooperate as the adult assists, by raising arms, stepping out of shorts, etc. The child who needs help undressing but is cooperative may be rated as compliant as the child who is capable of undressing him/herself and does so. Highly compliant/cooperative children tend to listen carefully to the adult's instructions during the height and weight measurements and comply without delay.

1. Never/Rarely compliant. The child typically resists complying to all requests and instructions. The child rarely if ever complies immediately. The nature of noncompliance may take the form of "no" assertions, angry defiance, whiny unwillingness, and/or passive behavior. Cooperativeness is very difficult to achieve.
2.
3. Moderately compliant. The child complies readily to some requests, but resists complying about half the time. Cooperation is achieved with extra effort on the adult's part.
4.
5. Always compliant. The child complies readily to all requests. Cooperation with the VC occurs immediately or almost immediately and with ease.

b. Assertive Noncompliance

This rating indexes the child's self-assertion. It captures reasonable attempts by children to distinguish their own needs and desires from others'. The expressions of uncooperativeness are not hostile, angry, or otherwise high in negative affect. They can be simple refusals to do what is requested, statements or explanation of the child's own preferences or desire, excuses, delaying tactics, or attempts to negotiate/argue. The self-assertive refusals may seem stubborn or persistent, but there is not a sense of resistance for its own sake, or opposition out of anger at the adults or the situation.

The child's resistance in the procedure may be both assertive and defiant. For example, self-assertive verbalizations may occur, but with further pressure to comply (especially if mother intervenes in a power assertive fashion) may escalate into angry expressions. Even emphatic refusals ("No!") can indicate assertiveness as long as the emphasis does not indicate anger. A refusal accompanied by negative affect should be coded as defiance, not assertive noncompliance. The distinction is sometimes subtle; the coder may only be able to go with a global "feel" for the affect contained in the child's expression.

Requests for help from the child in getting undressed should not be considered delaying tactics, but rather cooperative efforts.

Behavioral examples of assertive noncompliance:

Outright refusals when asked to do something: saying "no" or shaking head "no"; "I won't" "no, not today." Excuses/delaying tactics: "I'm too tired"; "I can't"; "I'm too little"; "I'm not ready." Negotiation attempts: "Why?"; "You do it"; "I'll do it later"; "Do I have to?" Nonverbal indications of refusal such as clasping the arms in front of the chest and standing rigidly. Attempts to leave the room.

1. Never assertive. The child is never assertively resistant to requests.

2.

3. Moderately assertive. Instances of self-assertive noncompliant behavior occur, but not frequently. Child is moderately self-assertive some of the time.
4.
5. Highly assertive. Child is frequently and clearly self-assertive in efforts not to cooperate with the procedure.

c. Defiant Noncompliance

This rating indexes the child's hostile, angry, or affectively negative resistance or opposition to the adult's requests. This is more than simple unwillingness to comply. The defiant behavior occurring in response to the adult's requests seems primarily directed toward resisting or antagonizing the adult, rather than negotiating a different situation.

Defiance includes doing exactly the opposite of what is requested, intensifying the behavior that is "off limits," and angry or aggressive responses to requests, including yelling, stomping feet, having a temper tantrum. Verbalizations that may be considered assertive ("No, I don't want to") but are delivered with anger should be considered defiance.

1. Never defiant. The child is never defiantly resistant to requests.
2.
3. Moderately defiant. Instances of defiant noncompliant behavior occur, but not frequently. Child is moderately defiant some of the time.

4.

5. Highly defiant. Child is frequently and clearly defiant in the procedure. Defiance is a consistent style of response to requests.

2. Contextual Features

a. Child Fearfulness

This rating is a judgement of the degree to which the child responded to this setting or procedure with fear. Some children have a fear of the doctor or the doctor's office. They may equate the growth measurement situation with experiences at the doctor's office and behave fearfully in this procedure. Care should be taken not to judge a seemingly "over-compliant" child as fearful. Signs of fearfulness could include behavior such as crying accompanied by struggles to leave the setting, clinging to the mother, burying the head in mother's arms. Typically the mother will comment that her child is afraid of the doctor and the scales are frightening him. If a mother comments that her child is afraid of the doctor but the child gives no indication of reacting fearfully to this procedure, do not assume the child is fearful.

1. None. No signs of fear of the setting.
2. Some. Some signs of fear of the setting.
3. Strong. Strong signs of fear of the setting.

b. Quantity of Maternal Involvement

This scale addresses the degree to which the mother is involved with encouraging her child to comply with the requests accompanying the height and weight measurements, whether or not such involvement is actually helpful in obtaining the child's cooperation. The quality of the mother's assistance is not to be addressed in this scale, merely the amount of involvement. A subsequent scale will be used to capture qualitative aspects of maternal involvement, namely "hindrance." Because most mothers assist their children in removing their shoes and undressing, such assistance, in the absence of additional encouragement to cooperate, is rated a 1. Additional involvement, such as repeating the experimenter's requests, coaxing, praising, additional directions, arguing, etc. are rated as a 2 or 3, depending upon the degree of involvement. Mothers whose children are uncooperative in this procedure are likely to get involved in obtaining their cooperation. Cooperative children may also have mothers who involve themselves in the procedure, repeating the experimenter's instructions, praising their child, and the like. A "3" on this scale should be reserved for mothers who are judged to be involved "a great deal" and seem to work as hard as the experimenter in obtaining the child's cooperation with the measurement procedures.

1. No/little involvement. Mother does not participate in the procedure beyond assisting her child to remove shoes and/or clothing.
2. Moderately involved. Mother is moderately involved in obtaining her child's cooperation with the measurement procedure.

3. Highly involved. Mother is very involved in obtaining her child's cooperation with the measurement procedures.

c. Maternal Hindrance

This scale addresses the degree to which the mother's involvement interferes with obtaining the child's cooperation in the procedure. Mothers rated high on "hindrance" are judged to have impeded the child's willingness to cooperate by giving too many directions or demands ("barraging" the child with instructions) or by directing the child in such a fashion that the child's "no" is directed more to the mother than to the components of the procedure themselves. Cooperative children, whether or not the mother involves herself, should be given a "1." When mother's efforts to gain her child's cooperation are effective, a "1" is appropriate as well. A "2" is given when it is perceived that the mother's involvement sometimes interfered, but sometimes helped. A "3" is reserved for mothers whose involvement in the procedure seems to impede the child's cooperation.

1. No hindrance. Mothers are either not involved or their involvement is helpful in obtaining child's cooperation.
2. Some hindrance. Some of the mother's tactics in obtaining child's cooperation are ineffective or seem to impede child's willingness to cooperate. Other tactics are helpful.

3. Much hindrance. Many of mother's tactics in obtaining child's cooperation are ineffective or seem to impede child's cooperation.

X. GOOD TECHNIQUES TO GAIN THE CHILD'S COOPERATION

A. General

Several of the mothers convinced their children to cooperate by promising them something. This worked very well. The vc might want to promise the child that he/she can play with a special toy after they are finished. Be sure to have an attractive toy handy if you use this strategy.

One site demonstrated the height and weight procedure with the reluctant child's older sister. This worked very well as the child cooperated with the vc after seeing his sister being weighed and measured. The height procedure can be demonstrated with the mother (or even another person at the lab) if there are no siblings present and if she agrees.

Another strategy that has worked well is blowing bubbles. The VC can blow bubbles for a while, or the mother can blow bubbles while the child is being measured.

The VC should give the child a sticker when completing the procedure. The sticker can also be used to get the child to cooperate.

B. Weight

One site allowed the child to hold a Nerf ball while he was being weighed. The child enjoyed the ball, and it did not weigh anything. Good idea.

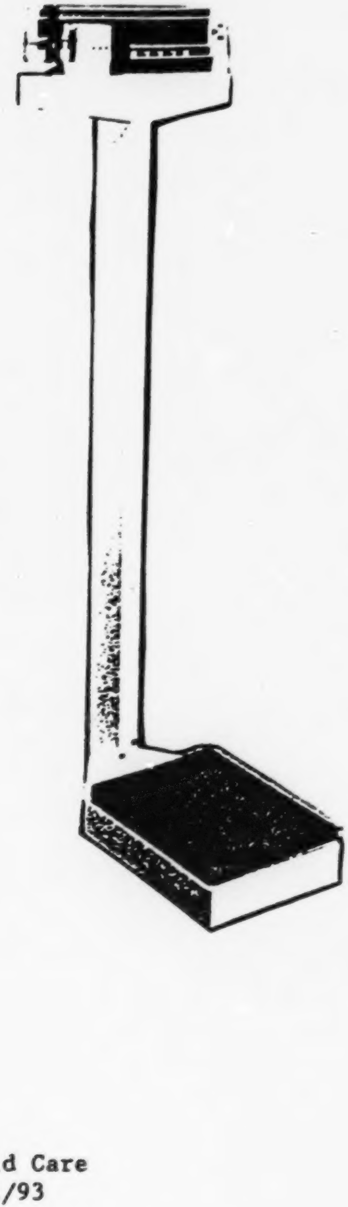
C. Height

Another site allowed the child to have her height measured first while sitting down. After the child realized that the procedure did not hurt, she cooperated by standing up.

One site put footprints on the floor where the children stand while the height assessment is made. This worked wonderfully to get the children in the correct position, as the children were able to put their feet on the footprints.

XI. APPENDIX

A. Detecto Physician's Scale Model #437



B. Scale Calibration - Form 14H

SCALE CALIBRATION

The Health O Meter Pediatric Balance Beam Scale is to be calibrated every week using the 25 lb standard weight provided by NICHD. To calibrate, zero balance the scale, place the 25 lb weight on the scale platform, and weigh the standard weight. If the weight is within ± 4 oz. of 25 lbs, the scale is accurate. If not, professional calibration is required.

Date of Calibration	Calibrator ID	Weight of standard in pounds & ounces	Professional calibration needed	Date scale professionally calibrated	Professional calibrator
			Yes____ No____		
			Yes____ No____		
			Yes____ No____		
			Yes____ No____		
			Yes____ No____		
			Yes____ No____		
			Yes____ No____		
			Yes____ No____		
			Yes____ No____		
			Yes____ No____		
			Yes____ No____		
			Yes____ No____		
			Yes____ No____		
			Yes____ No____		
			Yes____ No____		
			Yes____ No____		
			Yes____ No____		
			Yes____ No____		
			Yes____ No____		
			Yes____ No____		
			Yes____ No____		
			Yes____ No____		

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C. Height Measurement - Form 24G

HEIGHT MEASUREMENT

MARK CODING PERIOD 24 36

CHILD ID NUMBER

0	0	0	0	0	0
1	1	1	1	1	1
2	2	2	2	2	2
3	3	3	3	3	3
4	4	4	4	4	4
5	5	5	5	5	5
6	6	6	6	6	6
7	7	7	7	7	7
8	8	8	8	8	8
9	9	9	9	9	9

DATE

Month		Day		Year 199_
0	0	0	0	0
1	1	1	1	1
	2	2	2	2
	3	3	3	3
	4		4	4
	5		5	5
	6		6	6
	7		7	7
	8		8	8
	9		9	9

INTERVIEWER ID

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

Child weighed in			
	Diaper	Yes	No
	Underpants	Yes	No
	Tee shirt	Yes	No
	Socks	Yes	No
	Other	Yes	No

WEIGHT #1

lbs.		oz.	
0	0	0	0
1	1	1	1
2	2		2
3	3		3
4	4		4
5	5		5
6	6		6
	7		7
	8		8
	9		9

WEIGHT #2

lbs.		oz.	
0	0	0	0
1	1	1	1
2	2		2
3	3		3
4	4		4
5	5		5
6	6		6
	7		7
	8		8
	9		9

WEIGHT #3

lbs.		oz.	
0	0	0	0
1	1	1	1
2	2		2
3	3		3
4	4		4
5	5		5
6	6		6
	7		7
	8		8
	9		9

WEIGHT #4

lbs.		oz.	
0	0	0	0
1	1	1	1
2	2		2
3	3		3
4	4		4
5	5		5
6	6		6
	7		7
	8		8
	9		9

HEIGHT #1
inches (to 1/8")

		/8
0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
	6	6
	7	7
	8	
	9	

HEIGHT #2
inches (to 1/8")

		/8
0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
	6	6
	7	7
	8	
	9	

HEIGHT #3
inches (to 1/8")

		/8
0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
	6	6
	7	7
	8	
	9	

HEIGHT #4
inches (to 1/8")

		/8
0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
	6	6
	7	7
	8	
	9	

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D. Compliance Ratings in Growth Procedure - Form 38C

COMPLIANCE RATINGS IN THE GROWTH PROCEDURE

CHILD'S ID NUMBER

0	0	0	0	0	0
1	1	1	1	1	1
2	2	2	2	2	2
3	3	3	3	3	3
4	4	4	4	4	4
5	5	5	5	5	5
6	6	6	6	6	6
7	7	7	7	7	7
8	8	8	8	8	8
9	9	9	9	9	9

DATE

Month		Day		Year 199_
0	0	0	0	4
1	1	1	1	5
	2	2	2	
	3	3	3	
	4		4	
	5		5	
	6		6	
	7		7	
	8		8	
	9		9	

INTERVIEWER/OBSERVER ID

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

I. Child Behavior	NOT CHARACTERISTIC		MODERATELY CHARACTERISTIC		HIGHLY CHARACTERISTIC
1. Compliance	1	2	3	4	5
2. Assertive noncompliance	1	2	3	4	5
3. Defiant noncompliance	1	2	3	4	5

II. Contextual Features	NONE	SOME	STRONG
4. Child Fearfulness	1	2	3
5. Quantity of Maternal Involvement	1	2	3
6. Maternal Hindrance	1	2	3

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CHAPTER 29

Section ~~10~~ 12

CODING MANUALS

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CHAPTER 29

Section 9

CODING MANUALS

SUSTAINED ATTENTION

I. CODING METHODS: SUSTAINED ATTENTION

A. Introduction

For the purpose of this study, sustained attention is defined in terms of engagement with objects through exploration. Both visual and tactile exploration are coded. Visual attention usually guides the decision to code sustained attention since in sighted 15 months olds, tactile exploration rarely occurs without parallel visual attention.

The coding for sustained attention will follow procedures developed by Sarah L. Friedman (NICHD) with the assistance of Karen Livesey (NICHD) and Cheryl Edmonds (University of Washington). These procedures have grown out of procedures developed by Breznitz and Friedman (1988). The coding will be conducted at the University of Washington by Cheryl Edmonds and will be monitored by Susan Spieker (on site) and by Sarah Friedman.

The coder will view tapes of solitary play and will code instances of sustained attention by talking in to a microphone, which activates a computer program developed by Tim Myers of the

University of Washington. The computer program was designed to store information about the identity of the child, the date of data collection, the coder , and the date of coding. It was also designed to store detailed information about the child's sustained attention and related behavior of the adults who monitor the child's attention.

The computer program can provide the investigators with the following information:

1. Latency from "mother sits" to the child's first touching of a play object.
2. Latency from "child sits in front of toys" to the first touch of a play object.
3. Length of available play time from the first toy touch to the end of the session.
4. The reason the session was shorter than the expected 10 minutes from first toy touch:
    a. Technical;
    b. Child lost interest.
5. Total time the child is engaged with anything (physical or social objects) in the environment. Duration is reported in minutes and seconds.
6. Total time the child is engaged with physical objects.
7. Total time the child is engaged with the play objects (toys) available in the room.
8. Number of different physical objects attended.

9. average duration of first instances of sustained attention across physical objects.
10. Average duration of attention to physical objects that were attended to one at a time.
11. Average duration of attention to multiple physical objects.
12. Average number of social bids.
13. Average duration of attention to social objects.
14. Average duration of attention to a combination of social and physical objects.
15. Average number of adult attempts to refocus the child on toys.
16. Number of unoccupied bouts.
17. Total time spent unoccupied.

B. Materials

The coder of attention during the solitary play session must have access to videotapes of the solitary play procedure and to the coding equipment. The equipment consists of a videotape recorder, a monitor, and a computer equipped with the attention coding software.

The software allows the coder to first enter information about the coder's name or ID, the child's ID, the date at which the data was collected, the child's age at data collection and the date of coding. In addition, the software allows the computer to recognize the voice of the coder when she uses the limited lexicon needed for coding. The list of words recognized by the computer is as follows:

1. Block; 2. Bowl; 3. Bottle-miniature; 4. Hair-Brush; 5. Car; 6. Cat; 7. cloth; 8. Clothpin; 9. Doll; 10. Doughnut; 11. Horse; 12. People; 13. Sea Shell; 14. Spoon; 15. Stick-blue; 16. Stick-yellow; 17. Teapot; 18. Teapot-lid; 19. Telephone; 20. Telephone-receiver; 21. Other; 22. Social; 23. Scan; 24. Refocus; 25. Technical; 26. Unoccupied.

C. Coding Procedures

1. An Overview

First, the time at which the mother and child enter the room is entered and then the time the mother is seated is also coded. The coding of the child;s sustained attention starts when the mother has taken her eat and the child is either in her lap or standing next to her. The coder continues to code until the end of the session, usually 10 minutes following the child's first touching of one of the toys in the semi-circle. The coder is observing the child and the solitary play environment with the intent to code the following occurrences:

The child is playing with one or more of the 20 toys in the semi-circle (see list above). The child is exploring visually and/or touching other objects in the room (e.g. door knobs, window, heating vent). The child is interacting with the mother or the experimenter (e.g. talking to, showing objects, touching). The child is scanning the room, looking for play opportunities.

The child is unoccupied (e.g. not interested, sleeping, or crying). The child is straying out of site or turning his/her back to the camera. The child is being encouraged by the experimenter or the mother to refocus on the toys.

As mentioned earlier, for the purpose of coding attention in this study, sustained attention is defined in terms of visual and tactile exploration of physical and social objects, Consequently, when a child manipulates objects in a stereotypical fashion but is looking elsewhere, attention is not coded. Attention is coded when the child explores one object at a time as well as when the child explores several objects simultaneously. When a child is uninvolved with eh external environment, no code of focused attention is entered. Rather, the coder nates that the child is unoccupied.

2. The Units

The child has twenty toys available to him or her. In addition, there are objects that are part of the playroom environment and two adults that are engaged in a conversation. These physical and social objects can be engaged with individually or in different combinations.

There are 2 toy objects that can be coded in two different ways, depending on the circumstances: The telephone and the teapot.

1. The unit "Telephone" is coded when a child attends to the receiver and the base as they appear together at the start of the session (receiver on top of the telephone) or when the two

components are in very close proximity to each other. When a child plays with the base of the telephone only, the unit "telephone" is also coded. The "telephone-receiver" code is used when a child plays with the receiver away form the telephone base.

2. "Teapot" is coded when a child attends to the teapot and lid as they appear together at the start of the session (lid is on the top of the teapot) or when the two components are in very close proximity to each other. When a child plays with only the body of the teapot, the "teapot" code is used. The "teapot-lid" code us used when a child plays with the lid away from the pot.

When a chid plays with objects other than the toys provided, this is noted as "other". Objects subsumed under the "other" category include door knobs, windows, curtains, carpet,posters, their own clothing, mirrors, etc.

When a child looks at, approaches or interacts with the mother or the experimenter (visit coordinator), a "social" code is entered. However, if a child stands near or leans against the adult but does not look at her or interact with her, code of sustained attention is entered. The "social" code can be used in combination with "toy" and the "other" code.

When a child is actively looking around the room, either while sitting or walking, a "scan" code is entered. When the "scan" code is activated, no other code can be active at the same time. When a child is engaged with the environment, the experimenter intervenes and attempts to refocus the child by tapping the tops of toys or by instructing the mother to act in a way that might refocus the child. When on of the two adults is attempting to refocus the child, the "refocus" code is entered. When the "refocus" status is active, no other code can be active at the same time.

When a child strays our of the view of the camera or physically turns away so the direct observation is impossible, a "technical" code is coded. During this status, the 10 minute timer is suspended until normal coding can resume. when the "technical" code is active, no other code can be entered. If the child cries, sits without visually exploring or falls asleep, the "unoccupied" status is noted. When the "unoccupied" code is active, no other code can be entered at the same time.

3. The act of coding

The first step in coding attention is to train the computer program to recognize the voice of the coder before a specific coding session begins.

The program is very sensitive to variations in voice and intonations and may not recognize the same coder form one day to the next.

The next step involves providing the computer with information such as the chid's ID, the time the mother entered the room with her child, and the time she sits in her chair. all the child's acts of sustained attention as well as the adults' attempts to focus the child are noted by saying out the name of the event, using the words spelled out above (under "the units"). Saying the name activates a timer in the computer program. To deactivate the timer, the coder says the name of the dame unit again. The coder deactivates the timer that is associated with a given category when the child finishes attending to that category. The computer program allows parallel timers to be activated. So, by mentioning one unit and then another, the computer accumulates a record of simultaneous events. different combinations of events can be recorded with this system. The coder has to be very alert to capture the multiple, simultaneous events with their initiation and termination. The task is made less daunting by allowing for a 2-3 second delay when making coding decisions. For the purpose of this study we do not need information about fleeting instances of attention to the environment.

Real data tapes that the coder finds difficult to code will be viewed as many times as it takes to comfortably capture the attention events. Once the coder feels that she or he have resolved the difficulty, the tape is coded again.

D. Training of Coders

The training of Cheryl Edmonds, one of the coders for sustained attention and the familiarization of susan Spieker with the attention coding system was conducted by Sarah L. Friedman. The training led to some modification in the system due to questions, comments and suggestions by Cheryl. Cheryl Edmonds and Tim Myers demonstrated the use of the computer program. The second coder will be trained by Cheryl Edmonds. Cheryl will giver her an orientation. The new coder will code two tapes with Cheryl. The next step would be learn how to interact with the computer coding system. The new coder will then code six additional practice tapes (ratio of 2:1 of tapes of active to non-active kids is recommended, since active kids are harder to code). She will compare her coding to Cheryl's and differences will be discussed.

In order to ensure that Sarah and the coders agree on the details of the coding scheme, 6 pilot tapes will be coded and then sent with an audiotape overlay including hard copy documentation from the data files and the videotapes. The 6 tapes will be of 4 very active children and 2 more passive children; of the 6 children, 3 will be boys and 3 will be girls. Once Sarah has provided feedback and adjustments have been made, training will begin for all coders. This training will include an orientation and practice coding without using the computer software. Then the coder will be familiarized with basic DOS and the computer coding software.

E. Certification and Reliability

Certification will be based on the reliability scores of pairs of coders who coded 6 pilot tapes. The tapes will be of 3 boys and 3 girls with a ratio of 2:1 of active to non-active boys and girls. It is expected that reliability as calculated by intraclass correlations should not be below .85 and the mean reliability across tapes should be about .90. If the certification reliability between coders is below the standards, sources of difficulty will be discussed and it will be determined if more practice is needed. Once coding of real subjects begins, every 20th tape will be coded for reliability.

I. MATERNAL CONTROL AND AFFECT

Toddlerhood is a period in which children must establish their own autonomy while learning to accept limitations, in line with parental socialization goals and the needs of others. Thus, parents must tread a fine line between providing appropriate control, that is control that is neither too overbearing (i.e., not allowing adequate autonomy), nor too permissive (i.e., providing inadequate amounts of direction, structure). Control that is too overbearing may reflect hostile overcontrol or overinvolvement that is positive in affective tone, but still does not provide the child sufficient opportunity to function as an independent being. On the other hand, undercontrol may reflect lack of engagement and involvement with the child or a misguided attempt to permit autonomy and not to thwart the child's expression of impulse and desires. The scales of over- and undercontrol are not mutually exclusive. A mother may be low in overcontrol because she is sensitive, of because her child is highly cooperative and does not elicit much control, or because she is disengaged. Conversely, a mother may be low in undercontrol, or because she is appropriately sensitive and supportive, because she is overcontrolling, or because her child is compliant. The ratings of sensitivity/guidance and dyadic cooperation, as well as the affect ratings, are meant to clarify the meaning of the under- and overcontrol rating for each dyad.

A. Sensitivity/Guidance

Mother shows an awareness of child's tendency to be compliant or non-compliant and she tailors her initial instructions and follow-up behaviors appropriately. For children who are highly cooperative this means she is relatively nondirective, allowing the child to take the lead and providing appropriate encouragement and praise; for children who tend to be less compliant, this means providing the appropriate amount of structure and guidance, but in a positive and clear (potentially firm), but non-hostile manner. Mother is tuned in to the child's verbal and behavioral communications and responds appropriately to her/his needs for autonomy, direction, structure, or self-direction; mother may use bargaining, game playing, negotiations, explanations, or suggestions to facilitate compliance and move the child along; she shows understanding of the child's meed and agenda, as reflected in verbalizations that validate the child's feelings or that are appropriately responsive and tuned in to child's ongoing behavior or desires (e.g., putting a toy away); offer help when the child seems to need it; or be responsive to the child's bid for assistance. However, sensitivity comes in appropriate doses; too much may verge on overcontrol. Compliance is not a necessary outcome of sensitive guidance.

1. Mother is very insensitive to the child's needs and agenda.
2.
3. Mother shows some sensitivity, but it is mixed with insensitivity.
4.

5. Mother is very tuned int o the child an aware of needs , agenda, etc., during the entire clean-up episode.

B. Overcontrol

This rating is meant to capture maternal behavior that is intrusive and overcontrolling, and that does not allow the child sufficient autonomy in completing the clean-up task. It is independent of the quality of affect (which is rated separately), although overcontrol may be associated more often with negative affect and annoyance at the child, inducing threats and prohibitions. Some mothers, however, are overcontrolling by simply doing too many seemingly good things.

Mother gives many commands or directives or a constant string of suggestions; she is constantly monitoring the child's behavior and progress on the task and directing her/his behavior; this may include physically forcing or otherwise moving the child (e.g., taking child's hands and making him/her pick up a particular toy); she may interrupt an appropriate or inappropriate activity or redirect the child, without allowing time for transitions or for the child to express his/her wishes or to take initiative in completing the task; mother has her own agenda and is not interested in letting the child pursue his/her own agenda and is not interested in letting the child pursue his/her own agenda, regardless of whether or not it is on task.

1. Mother is not al all overcontrolling; she provides appropriate control or she allows the child autonomy.
2.

3. Mother is overcontrolling for part of the time; she is highly directive for portions of the clean-up, but also backs off and gives the chid a chance to do the task independently or to pursue his/her own agenda for a portion of the time.
4.
5. Highly overcontrolling for most of the activity.

C. Undercontrol

This rating is meant to capture maternal behavior that is insufficiently supportive and provides and inadequate amount of structure or scaffolding for the child's activities. It may reflect maternal disengagement and lack of investment or a laissez-faire, overly permissive approach to the child's behavior. It is important to recognize that undercontrol involves providing too little control because it is often appropriate to allow the child some degree of autonomy in managing the situation.

Mother lets child do what he/she wishes; if chid continues to play with the toys, mother may just sit and watch and say mother; she is involved only minimally with the child; or she totally lets child take the lead without redirecting inappropriate task-related behavior or encouraging or praising appropriate task-related behavior. Other examples include the following: the child is off task for a prolonged period and mother fails to redirect the child; the child is making an effort and obviously needs help, but gets none; the child is being very compliant and getting no praise or recognition for his/her efforts; these would all reflect undercontrol.

1. Mother is not al all undercontrolling.
2.
3. Mother is undercontrolling for part of the session, letting the child do what s/he wants for long, but if child continues to show no signs of cooperating, she eventually intervenes to redirect behavior.
4.
5, Mother exerts almost no control over the child for the entire episode, despite the fact that the child is not complying with the request to clean up the toys.

D. Positive Affect

This rating assesses the extent to which the parent displays warmth, nurturance, and positive affection toward the child and enjoys interacting with the child, with extent defined in terms of both frequency and intensity. Behaviors that evidence such an orientation are numerous and diverse. Among others, they include kissing and hugging the child, affectionately touching the child and smiling at and laughing with the child as well as being enthusiastically involved in what the child is saying or doing. Especially important is the provision of praise and positive encouragement for cleaning up.

1. No instances of warmth, affection, or enjoyment are observed. Parent is instructional or uninvolved.
2.
3. Some instances of warmth, affection, enjoyment are observed. Parent may laugh with the child, show enthusiasm, or offer some praise.
4.
5. Instances of warmth, affection, praise and/or enjoyment are very frequent.

E. Negative Affect

This rating assesses the extent to which the parent displays hostility, negative affect, and displeasure of annoyance toward the child, with extent defined in terms of both frequency and intensity. Behaviors that evidence such as orientation are numerous and diverse. They include annoyed or scornful facial expressions and posturing, aggressive handling of the child, explicitly negative or scornful vocal tones, and clear lack of enjoyment of the child in this situation.

1. No instances of hostility, negative affect, or displeasure are evident.
2.
3. Some instances of hostility, negative affect, or displeasure/annoyance occur, but there is not escalation in intensity or loss of control.
4.
5. Instances of hostility, negative affect, and displeasure are frequent and/or intense or pronounced.

II. CHILD COMPLIANCE-NONCOMPLIANCE AND AFFECT

One of the primary tasks of toddlerhood is to achieve autonomy in a social world that demands both independence and compliance. These ratings are meant to capture the frequency and quality of the toddler's compliance and noncompliance to maternal requests. It is important to recognize that both compliance and noncompliance increase with age over the toddler years, and that both are evidence of positive developmental change. Thus, saying "no" by a toddler is a sign of emerging autonomy, a major development achievement. There are also individual differences in both compliance and noncompliance, however, and too much or too little of either can be non-normative.

These ratings fist identify how compliant or cooperative the child is with adult requests and direction. When the child is noncompliant, the ratings also index 3 distinct forms of noncompliance that differ in the extent to which they indicate competent autonomy behavior. Simple whining, fussing, or pouting will be captured in ratings of negative affect rather than in noncompliance.

A. Compliance

This scale captures the degree to which the child willingly follows or cooperates with the adult's requests. This can happen in any of several ways. The child may have negotiated a satisfactory course of action that also coincides with the adult's wishes. the child may be about to do, or already be doing what the adult asks. The child may be cooperative.

This scale does not index the intensity, quality, or form of noncompliance, only the frequency of compliance/noncompliance--how easy or difficult it is to get the child to cooperate with the adult's directions, requests, or demands.

1. Child complies nearly all the time, and does so immediately and willingly. There is very seldom noncompliance, and noncompliance is weak or short-lived.
2.
3. Child complies some of the time. This may occur because compliance is only achieved after several episodes of noncompliance. Alternately, immediate compliance in some instances may be offset by a few intense episodes of

noncompliance, or by more frequent instances of weak noncompliance.

4.

5. Child is predominantly noncompliant, even when the parent is firm or insistent. Noncompliance can take any form, but child almost never complies, even after multiple attempts by adult to achieve compliance. The child doe virtually nothing of what is requested of him/her.

B. Autonomy Bids/Self-Assertion

This rating indexes the toddler's self-assertion and growing autonomy. It can be considered "realistic negativism" (Crockenberg & Litman, 1990). That is to say, it captures reasonable attempts by toddlers to distinguish their own needs and desires from those of others around them, and their attempts to establish their independence and "selfhood."

Autonomy bids are not hostile, angry, or otherwise high in resistance or negative affect. They can be simple refusals to do what is requested, statements or explanations of the child's own preference or desire, excuses, delaying tactics, or attempts to negotiate/argue. The child may be stubborn or persistent in the noncompliance, but there is not the sense of resistance for its own sake, or opposition out of anger at the parent of the situation.

Toddlers are often both autonomous/assertive and defiant. We well code defiance separately (see below). However, sometimes autonomy and defiance will occur in the same behavioral episode, mixed. For example, a child may deliver an assertive verbalization ("no") accompanied by angry affect. In this case, code the behavior as defiant, not as autonomous. Other times, though autonomy and defiance will occur sequentially--the child will start out being assertive, but with further pressure to comply from the adult, will become defiant. In this case, the child would receive scores for both autonomy and defiance.

Examples of autonomy bids/selfassertion:

Outright refusals when asked to do something: saying"no" or shaking head for "no"; "I won't"; "uh-uh"; "no, thank you."

Statements/explanations of own preference or desire: "I don't want to"; "I want to play"; "I don't like to"; "I don't feel like it."

Excuses/Delaying tactics: "I'm too tired"; "I can't"; "I'm too little"; "I'm still playing."

Negotiation attempts: "Why?"; "You do it"; "I'll do it later"; "Do I have to?"

1. Child never exhibits autonomy bids. Either the child always complies, or else the noncompliance exhibited never includes autonomy bids.
2.
3. Child exhibits autonomy bids some of the time. At other times child is either compliant or exhibits some other form of noncompliance.
4.
5. Child's predominant from of noncompliance is autonomy bids. For this rating the child may be largely compliant or largely noncompliant. Regardless of the rate of noncompliance, the form of noncompliance is almost exclusively autonomy bids.

C. Defiance

This rating indexes the toddler's hostile, angry or affectively negative resistance or opposition to the mother's requests for demands. This is more than simple unwillingness to comply, or a desire to differentiate oneself from the rest of the social world. It is "negativism for its own sake" (Crockenberg & Littman, 1990). The child's behavior seems primarily directed toward resisting or antagonizing the adult and is both more intense and often more persistent than autonomy bids.

Defiance includes doing exactly the opposite of what is requested, intensifying the behavior that is "off limits," and angry or aggressive responses to requests, including yelling, throwing things, hitting and kicking, having a temper tantrum, etc. If a verbalization that might be considered an autonomy bid ("No," "I don't want to") is delivered with anger, it is defiance.

1. Child is never defiant. Child may always comply, of noncompliance may never fall in this category.
2.
3. Child is defiant some of the time, but some of the time child is either compliant or exhibits other form of noncompliance.
4.
5. Child is predominantly defiant. Child may be largely compliant or largely noncompliant, but the form of noncompliance is almost exclusively defiance.

D. Passive Noncompliance

While both autonomy bids and defiance are active forms of noncompliance in which children make their unwillingness to cooperate with adult requests unequivocal, passive noncompliance is just that. The child fails to comply but does so without overt defiance or refusal. This will mostly take the form of ignoring the request. It also includes changing the subject or changing activity to one not requested (but not directly contradictory--e.g., taking toys out of basket or throwing them is defiance; playing with a different toy is passive noncompliance).

1. Child is never passively noncompliant. Child either always complies, or exhibits other forms of noncompliance besides passive.
2.
3. Sometimes child is passively noncompliant. Other times the child is either compliant or exhibits other forms of noncompliance.
4.
5. Child is predominantly passively noncompliant. Child may be either predominantly compliant or noncompliant, but the main form of noncompliance when exhibited is passive.

E. Positive Affect

This scale assesses the degree to which the child is obviously happy and having fun. The best indications of this are facial expressions (laughs, smiles) and tone of voice. A child high in this scale clearly would be having a good time, with spontaneous and zestful expressions of fun, delight, and bubbliness. A low score in this scale does not indicate anything about overt negativity and so this scale assesses the presence of indications of positivity, not absence of negativity.

1. No explicit indicators or positivity observed.
2.
3. Some evidence of pleasure is apparent via laughs, smiles, etc.
4.
5. Child is clearly having a very good time, as revealed by smiles, laughter and tone of voice.

F. Negative Affect

This rating assesses the extent to which the child is distressed, angry, hostile, or in some other way manifests unhappiness and displeasure. Behavior that evidence such an orientation are numerous and diverse, and include crying, pouting, throwing objects, stomping feet, yelling, screaming, sneering and the like. In making this rating both intensity and frequency should be taken into consideration.

1. No evidence of negative affective expression is displayed.
2.
3. Child displays some or modest evidence of negative affective expression. This behavior should not escalate into an extensive display, i.e., they are somewhat isolated behaviors.
4.
5. Child very frequently or markedly displays anger and/or hostility.

III. DYADIC COOPERATION

This rating is meant to capture the quality of give and take during the clean-up. Mothers may be sensitive and still have noncompliant children; or they may be undercontrolling and still have compliant children. This rating is meant to more explicitly take into account the quality of the dyadic interaction, including positive vs. negative mood and cooperation/fun-taking, and the overall "feel" and tone of the interaction, as well as mother's success in gaining compliance without becoming overly directive or angry. It includes synchronous interactions between the dyad around the task.

1. There is almost no dyadic cooperation during the task; mother-child conflict is very high or there is little interaction or interchange between them.
2.
3. There is some dyadic cooperation and synchrony in the interaction during part of the observation.
4.
5. The entire segment is characterized by mutual cooperation, turn-taking or give and take interchanges, and a positive tone.

SEPARATION AND REUNION

36-MONTH SELF CONTROL RATINGS

I. LABORATORY FORBIDDEN TOY TASK*

Children manifest the ability to comply to outsider requests and to temporarily delay gratification at around two years of age. Kopp (1982) labels this the stage of self control in an effort to differentiate it from the next stage which she labels self-regulation. Self-regulation which occurs around 3 years of age addresses the child's use of diversional strategies to facilitate requests to delay gratification.

These aspects of the child's self control are assessed at 36 months in a laboratory delay of gratification task in which the child is asked by the experimenter to refrain from touching or playing with an attractive toy for a period of time. Self control is measured in terms of (a) the degree to which the child inhibits his or her desire to touch or play with the toy when told to delay touching, and (b) the style with which the child copes with the task, differentiated in terms of the degree of over-control or under-control as determined by ability to delay gratification, modulation of affect, and delay strategies employed.

A. Delay of gratification

B. Positive Affect During Delay

C. Negative Affect During Delay

D. Post Delay Affect

E. Under-Control

F. Over-Control

G. Constructiveness of Diversional Strategies

A. Delay of gratification

1. None. The child touches the toy immediately after being told not to touch. the child continues to touch and/or play with the toy throughout the 2-minute delay period.

2.

3. Partial. The child touches the toy briefly, and may pick it up, but either delays for part of the time before doing so or puts the toy back down and refrains from touching for some portion of the delay period.

4.

5. Full. The child does not touch or pick up the toy at any time during the delay period.

B. Positive Affect During Delay

This scale assesses the degree of positive affect the child displays throughout the period of delay. Indications of positive affect are seen in facial expressions (laughs, smiles) and tone of voice.

1. None. No explicit signs of positive affect are shown.
2. Some.
3. Moderate. Some evidence of positive affect or pleasure is seen via laughs, smiles, etc.
4. Moderately High.

5. High. Signs of highly positive affect are shown throughout period of delay as evidenced by smiles, laughter and tone of voice.

C. Negative Affect During Delay

This scale assesses the degree of negative affect the child displays throughout the period of delay. Indications of negative affect include distress, anger, hostility, or other manifestations of unhappiness and displeasure. Behaviors indicating negative affect include crying, pouting, throwing objects, stomping feet, yelling, tense facial muscles, and other signs of irritation and/or negative mood.

1. None. No signs of negative affect are shown.
2. Some.
3. Moderate. The child displays one instance of strong negative affect or several instances of moderate discontent.
4. Moderately High.
5. High. The child displays high levels of negative affect with several instances of strong negative affect or definite discontent throughout the entire period of delay.

D. Post Delay Affect

This scale addresses the child's enjoyment in playing with the toy after he/she is given permission to play with it after the period of delay. This is signaled by the experimenter saying, "I finished my work. We can play some more now with the

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dog." In cases where the child does not inhibit touching or playing with the toy during the period of delay, this scale will be rated on the affect exhibited after the experimenter terminates the delay period and says "... We can play some more now with the dog" and joins the child near the play surface.

1. None. No pleasure in play with the toy is exhibited. The child may appear bored, tense, nervous, fearful, or show signs of displeasure (verbally and/or physically).
2. Very Low. The child may show some interest in playing with the toy but affective expressions are neutral.
3. Moderately Positive. Enjoyment in playing with the toy is expressed by intermittent smiles or verbalizations indicating pleasure but expressions are more low-keyed than higher scores and pleasure does not predominantly characterize the child's response.
4. Positive. Pleasure in playing characterizes the child's response but the indicators are less exuberant than a rating of 5.
5. Highly Positive. Enjoyment is expressed by sustained episodes of big smiling, laughing, and other signs of exuberant playfulness. The child indicates that playing with the toy is very fun.

E. Under-control

"Under-Control" is characterized by little or no ability to delay gratification or to control impulses, hyperactivity and distractibility, and the immediate expression of affects in uncensored form regardless of the appropriateness of such behavior in the situation.

1. Not at all under-controlled.. The child controls his or her impulses to touch or play with the toy.
2.
3. Moderately under-controlled. The child has difficulty in modulating impulses, but may show some organized attempts towards behavioral and affective regulation.
4.
5. Very under-controlled. The child has obvious problems moderating behavioral and affective responses. The child does not show planful, organized behavior or affective restraint. Affect may be negative. Child may become disorganized by the task and efforts to cope with the situation are unsuccessful and not adaptive.

F. Over-control

"Over-Control" is characterized by excessive modulation or constriction of feelings and responses to events, particularly when that degree of control over emotions and behavior is unnecessary (e.g. when given permission to play with the toy).

The highly controlled child tends to appear overly constrained in the situation.

1. Not at all over-controlled.
2.
3. Moderately over-controlled. The child tends to show moderated responses to the situation and is mostly well-organized in his/her approach to the delay. Affect may seem somewhat muted and the child may not appear to allow him/herself the spontaneity and interest that would be expected in the situation.
5. Very over-controlled. The child is highly regulated in his/her response to the situation. She/he may give a strong impression of inhibition, flat affect, and little spontaneity. the child may seem "frozen" and/or unfocused and appears unable to utilize more adaptive coping strategies in efforts to deal with the delay request, in spite of an ability to control the desire to touch the toy. Following the delay the child shows a marked delay of affective responsiveness or a total absence of pleasure. Overall, the child portrays a picture of strong inhibitions and repression of impulses.

G. Constructiveness of diversional strategies

1. Not constructive. The child uses no diversional strategies. He or she focuses exclusively on the toy, perhaps talking about it as well.

2.

3. Moderately constructive. The child focuses away from the toy at least some of the time but strategies are not particularly constructive, for example, the child may spend most of the time looking back and forth between the experimenter and the toy or may look away or walk away from the toy only to return repeatedly, perhaps touching it.

4.

5. Highly constructive. The child utilizes constructive and adaptive diversional strategies (e.g., playing with other toys, exploring the room) to deploy attention and deal with the delay of gratification.

24-/36-MONTH QUALITATIVE RATINGS OF MOTHER-CHILD INTERACTION

I. GENERAL INSTRUCTIONS FOR APPLYING THE QUALITATIVE RATINGS OF MOTHER-CHILD INTERACTION

Each set of qualitative rating is to be based on 15 minutes of videotaped semi-structured observation of the mother and her child. The procedure for structuring the mother-child interaction is one in which the mother is instructed to show her child toys that are contained in three sequentially numbered boxes. The mother is told that she should feel to play with her child or not.

In determining the ratings it is helpful for the coder to take longhand notes of mother and child behaviors as they relate to each scale and organize the notes by coding category on the worksheet titled "Qualitative notes." In assigning a rating, the coder should use a two-step process (borrowing from the logic used by Harter). The first step is to ask, "Is this dimension 'characteristic' (a 3 or 4 rating) or 'not characteristic' (a 1 or 2 rating) of the person being rated?" Once this decision is made, then the rater needs to make a finer discrimination between 3 or 4 and 1 or 2 ratings.

Rating for most of these scales should be based on both the quality and quantity of the observed behaviors in relation to the proportion of the item they were observed. Ratings of 1 and 4 should be reserved for those observations that could be considered either problematic or exceptionally advantageous, depending on the specific scale.

A. Mother Ratings

Sensitivity/Responsiveness to Distress

This scale focuses on how the mother responds to the child's cries and other expressions of negative affect (including anger and temper tantrums). It is judged in the following three ways:

1) Proportion of distress signals responded to. What proportion of distress is responded to? The sensitive mother responds to all signals of distress.

2) Latency of response. How long does it take the provider to respond? The sensitive mother responds to distress quickly.

3) Appropriateness of response. Appropriateness of the adult's behavior might be inferred by its effectiveness in soothing the child as well as the completeness of the response should also be taken into account. For example, a mother who responds distally (e.g., voice from the other side of the room) should not be judged as sensitive as a mother who approaches and/or physically comforts the child. Mothers who do not acknowledge distress should be judged as less sensitive than those who do acknowledge the distress, however short lived. Caregiving responses to child distress generally involve speaking sympathetically to the child, approaching the child, distracting with toys or activities, hugging, patting, picking up, or holding in lap and rocking. For preschoolers, physical contact is not

always the most effective or even the most appropriate response to distress. Much depends on the intensity and cause of the distress. Calm reassurance, explanations, or negotiations are appropriate responses when the distress has a clear, explainable cause. When the cause of distress is unknown, the sensitive mother will try to determine the cause, often by asking the child. In addition to reassuring the child, the mother caregiver will also attempt to alleviate the cause, where possible (e.g., speak to another child who was the cause of the distress; help with a frustrating physical world problem). Any of these or other behaviors can be considered sensitive if they appear to have the effect of soothing the child. If the mother's first response to the distress does not soothe the child, which will happen more often with toddlers and preschoolers than infants, the sensitive mother should offer a "fuller" response or adapt a different strategy (i.e., more proximal soothing behaviors).

Ratings on this scale are composed of both qualitative and quantitative dimensions. The proportion of signals responded to and the latency of response time should be evaluated in relation to the quality of the response. For example, if a mother responds very slowly or not at all to the child, she should receive a rating of 1. A mother might receive a 2 if full responses are delayed or immediate responses are somewhat "shallow" or if there is a combination of such responses. A rating of 4 should be given to those mothers who exhibit immediate and exceptionally sensitive and appropriate responses.

1 = Not at all characteristic. This rating should be given to caregivers who are very insensitive and unresponsive. When the child is upset, the caregiver responds not at all, or very slowly or inappropriately. If there is a response, it is only after the child becomes very demanding, and the response is so delayed that it cannot be construed as contingent upon the child's behavior. A mother who typically appears oblivious or punitive to the child's distress would receive this score. She seems minimally interested in providing comfort.

2 = Minimally characteristic. This rating should be given to mothers who display infrequent or weak sensitivity/responsivity. While the mother is sometimes sensitive, the balance is clearly in the direction of insensitivity. The mother responds rarely or slowly to child's distress signals. The responses tend to be minimal or perfunctory or otherwise inappropriate. Often the mother's actions appear to increase the child's distress.

3 = Moderately characteristic. This rating should be given to mothers who are predominantly sensitive/responsive. The mother typically responds to child distress, demands and signals, but there is some time in which clear child signals do not receive a response or in which the response is somewhat delayed or are ineffective. Some of the mother's responses are mixed, i.e., some are half-hearted or

perfunctory, but the majority are full responses where the observer feels like "that was a good episode."

5 = Highly characteristic. This rating should be given to caregivers who are exceptionally sensitive and responsive to distress. The caregiver responds quickly and appropriately to the child's distress. If the child is upset, the caregiver takes time to soothe and calm the child. There may be proportionally few instances of ignoring and/or minimally responding to the distress, but overall most responses are prompt, appropriate, and effective.

9 = No opportunity to observe. No instances of child distress are observed or distress is only fleeting or very mild (and child receives a 1 on negative mood).

Sensitivity/Responsiveness to Nondistress (adapted from Fish, 1990)

This scale focuses on how the mother observes and responds to the child's social gestures, expressions, and signals. The key defining characteristic of sensitive interaction is that it is child centered. The sensitive mother is tuned to the child and manifests awareness of the child's needs, moods, interests, and capabilities, and allows this awareness to guide his/her interaction. In toddlers this also includes sensitivity to the child's own agenda, his needs for autonomy, independence, and mastery, and his individual self-regulatory abilities (and deficiencies). The sensitive mother structures the child's physical and social environment so that the child has legitimate, interesting options for play, so the child's preferences can be honored within reason, and so that the child can remain effectively engaged in playful or goal-directed activity. The sensitive mother also offers frequent praise and encouragement, withholds criticism, and provides the right mix of support and independence so that the child can experience master, success, pride, and develop effective self-regulation skills.

If the child initiates social gestures verbally or nonverbally (e.g., looking at the mother, reaching toward the mother, waving, clapping hands, handing objects, directing speech toward mother), or makes demands, desires, or requests known (stretching arms to be picked up, reaching for toys the mother is holding, asking for things or attempting to verbally request), the sensitive mother responds appropriately, based on the child's cues.

If the child appears disengaged, the sensitive mother takes time to reengage the child in a manner that demonstrates awareness of and sensitivity to the child's mood and preferences for play style and content. When the child is bored or frustrated, the mother offers toys, activities, or other engaging opportunities; or helps the child decide what to get involved with or help the child make the transition to the new activity. When the child is interested and involved with toys, the sensitive mother allows him/her time to independently explore them.

As much as possible the toddler is given choices for play. This includes choice of toy and how to play with them, or choices among mother structured activities, among roles in a game and so forth. How and what they play is geared to whether or not the child seems to be enjoying the activity. The mother either does not persist with an activity or toy that the child is obviously not enjoying, or tries to engage the child's interest by appealing to the child. For example, if a child doesn't want to sing with the group during circle time, the mother might ask the child to choose a song, or if s/he has a favorite song for the group to sing. The difference between toddlers/preschoolers is that older children are both more active and reactive in their likes and dislikes. Unlike infants, it is not always best for the toddlers and preschoolers to "have his own way." The sensitive mother, however, permits the child as much choice, control, and autonomy as possible even while enforcing necessary rules, regulations, and constraints.

A sensitive mother provides stimulation that is situationally appropriate. He/she acknowledges the child's interest, efforts, affect, and accomplishments. Sensitive mothers need not spend all the time engaged with the child, but the difference between them and the detached mother is that the sensitive mother seems to be actively taking an interest in the child's activities, as evidenced by comments, embellishments, or redirection when the child loses interest, achieves success or does something new and interesting. It is at these times that the difference between the sensitive mother and the detached, understimulating mother is most easily seen; the detached mother does not respond, responds in a listless manner, or responds with developmentally inappropriate comments and behavior. The insensitive mother could also be overstimulating/intrusive and might continue in his/her attempts to engage the child even when the child is providing clues that he/she is seeking to end the interaction.

A sensitive interaction is well timed and paced to the child's responses, a function of its child-centered nature. Such an interaction appears to be "in sync." The mother paces activities to keep the child engaged and interested, but also allows him/her to disengage if interest is lost and generally to shape the nature of the involvement. Sensitivity involves judging what is a pleasurable level of arousal for the child and helping the child to regulate arousal and affect. When the child loses interest, the sensitive mother offers a new activity and observes the child's reaction, or stops interacting entirely. In this way the sensitive mother can be distinguished from both an intrusive and a detached mother.

In the toddler years, the primary developmental issues no longer center on establishing a close relationship with a primary mother, rather they now center on establishing autonomy and control within that relationship, in concert with the self-regulation and compliance demanded by adults. At the same time as demanding independence, the toddler child struggles with it, often needing to be dependent as in infancy. The sensitive mother is flexible in supporting and responding to these aspects of development. When the child must change activities (e.g., it's time to eat lunch, to go outside, to clean up), the sensitive mother gives ample advance warning. She or he couches requests in positive terms, uses please and thank you, provides explanations, and avoids commands where possible. Sensitive mothers more often use terms like "let's do x" or "you (or we) need to do x now" or "I need you to do x now." The sensitive mother times her requests to coincide with changes in the child's interest or activities, avoiding interrupting the child who is highly involved in his/her play. The sensitive mother takes into account the child's personal style and ability to self-regulate (does this child dawdle more than others? does this child have difficulty with transitions? is this child distractible?) in the timing and content of requests. The sensitive mother recognizes and encourages the child's independence, but does not demand it. At the same time she or he permits the child to be dependent when the child needs it.

During the toddler years sensitivity to nondistress can also be inferred on the basis of how the mother manages disciplinary encounters. The sensitive mother is neither over controlling or detached, but rather is attentive to child behaviors that need sanctioning and responds in a way whereby the sanction fits the misdeed. Thus, behaviors that pose dangers to the child and others are responded to quickly and clearly and perhaps firmly (though not severely) in order to let the child know clearly that such actions are intolerable. Behaviors, in contrast, that represent rule violations (e.g., going to a part of the house that is off limits for cleanliness reasons) or discourtesies (e.g., taking another's toys) should be responded to less severely and perhaps with somewhat less immediacy (due to the absence of physical danger). Sensitive discipline frequently involves indication by the mother that s/he is aware of what motivates the child (e.g., "I know you wanted that toy;" "it's difficult to stay away from such pretty things, isn't it?") and the offering of an explanation or rationale for why the discipline is taking place (e.g., "that's dangerous, so I can't let you play with it;" "Sarah had the toy first, so she gets to keep it for now"), and/or a substituting toy or activity (e.g., "you may not pull out the colors now, but I will read you a book"). To be noted, however, is that excessive explanations and rationales can reflect insensitive-intrusive caregiving rather than sensitive caregiving. Long-winded speeches and lectures often reflect the mother's lack of awareness of the child's developmental level. Prohibitions that are at the whim of the mother rather than in keeping with appropriate guidelines for young children are not "child centered." Similarly, prohibitions that the child is incapable of understanding are manifestations of insensitive discipline. In sum, sensitive discipline is discipline that varies in accordance with the nature of the misdeed and suggests that the mother does not hold inappropriate expectations of the child in question.

Markers of sensitivity include (a) acknowledging the child's affect; (b) mother conversation that is responsive to the content of the child's talk and or activity; (c) facilitating, but not over controlling the child's play with objects or his/her motor activity; (d) evidence of good timing paced to the child's interest, activities, and arousal level; (e) changing the pace when the child appears understimulated, overexcited, or tired; (f) picking up on the child's interest in toys or games; (g) shared positive affect; (h) encouragement and praise of the child's efforts; (i) providing an appropriate level of stimulation and appropriate range and variety of activities; (j) timely discipline that matches the nature of the violation under consideration and the child's ability to understand and benefit from whatever reprimand is offered; and (k) general flexibility in handling compliance and autonomy issues, including not over-reacting to noncompliance and supporting autonomy while permitting dependence.

Thus, the sensitive mother demonstrates the ability to adapt her/his behavior to the child's mood and level of development. The mother neither over- nor underestimates the child's capacities. The mother knows when it is time to increase or reduce the amount of stimulation the child is experiencing. For example, the mother discontinues an activity that is beyond the child's capacity for response or introduces a new activity when the child appears bored.

Ratings on this scale should be based on both quality and quantity of caregiver behavior.

1 = Not at all characteristic. There are no signs of mother sensitivity. The mother may be either predominantly intrusive or detached. The mother rarely responds appropriately to the child's cues, and does not manifest an awareness of the child's needs. Interactions, if they occur at all, are characteristically ill timed or inappropriate.

2 = Minimally characteristic. This should be given to mothers who display infrequent or weak sensitivity/responsivity. While the mother is sometimes sensitive the balance is clearly in the direction of insensitivity.

3 = Moderately characteristic. This rating should be given to mothers who are predominately sensitive/responsive. The mother demonstrates sensitivity in many interactions but not in others, or may show some insensitivity while being predominantly sensitive (e.g., available and responsive to child's needs but some responses are more adult-driven than child driven).

4 = Highly characteristic. This rating should be given to mothers who are exceptionally sensitive and responsive to nondistress. Instances of insensitivity are rare and never

striking. Interactions are characteristically well timed and appropriate.

Intrusiveness/Over Control (adapted from Fish, 1990)

Intrusive and overcontrolling interaction is definitely adult centered rather than child centered. Prototypically, intrusive/overcontrolling mothers impose their agenda on the child despite signals that a different activity, level of play, or pace of interaction is needed. High arousal or a rapid pace are not, by themselves, indicative of intrusive overstimulation--if the child responds positively with sustained interest and does not engage in defensive behaviors. Intrusiveness and overcontrol are apparent when the mother does not allow the child a "turn" or an opportunity to respond at his/her pace. Some intrusive/overcontrolling mothers overstructure their children's play; they insist on their own agenda or play theme; they interrupt to redirect play; or they insist on particular uses for toys or props (e.g., "it's an apron not a hat"; an oven cannot be a space shuttle), when such control is not necessary for the child's safety or respect for others or their belongings. These mothers appear unable to relinquish control of the interaction in order to facilitate the child's exploration or regulation of the activity. Another example of controlling, intrusive behavior is displayed by mothers overwhelming the child with a rapid succession of toys or suggestions, not allowing him/her time to react to one before another occurs. Extreme intrusiveness can be seen as overcontrol to a point where the child's autonomy is at stake. It should be kept in mind that a mother can be involved in play with the child without being highly intrusive, if the mother follows the child's interest, pace, and signals.

Intrusive, over control is often observed with toddlers and preschoolers during disciplinary encounters. The intrusive-overcontrolling mother appears unresponsive to the whys and wherefores of a child's behavior that elicits discipline, instead imposing a system of rigid values and responses that risks obliterating the individuality of the child. Moreover, this kind of caregiving seems more driven by the mother's own moods and inflexible attitudes than by the developmental needs of the child. Thus, little distinction may be made in whether the mother is disciplining the child for engaging in truly dangerous behavior versus engaging in simply inappropriate or impolite behavior. In such instances, the mother does not modify the severity of her discipline in accordance with the seriousness of the child's behavior and is likely to show little interest or concern for the child's feelings or goals. Punishments by highly controlling and intrusive mothers are likely to not vary as a function of the severity of the misdemeanor and may reflect inappropriate expectations of what the child can be expected to do (e.g., a 15-minute vs. 3-minute time out when a 2-year old takes a toy from another child). It should be noted, too, that another way a mother can be intrusive and overcontrolling with regard to discipline is by over doing what would otherwise be judged appropriate caregiver behavior; for example, by going on endlessly explaining to a child why s/he should not do something or excessively drawing a child's attention to the consequences of his/her actions.

Specific behaviors characterizing intrusive/overcontrolling interactions include (a) failing to modulate behavior that the child turns from, defends against, or expresses negative affect to; (b) offering a continuous barrage of stimulation, food, or toys; (c) not allowing the child to influence the pace or focus of play, interaction, or feeding; (d) taking away objects or food while the child still appears interested; (e) insisting that the child do something (play, eat, interact) in which he/she is not interested; (f) not allowing the child to make choices, and (g) by excessively or abruptly disciplining the child.

Mother actions which are clearly in the child's best interests, such as removing a child from danger, administering medicine, intervening in escalating or physical conflict, or putting an obviously tired child to bed, are not included in considerations of intrusiveness.

Ratings of intrusiveness must be evaluated from the perspective of the child.

1 = Not at all characteristic. This rating should be given to caregivers who display no signs of intrusive or overcontrolling behavior.

2 = Minimally characteristic. This rating should be given to caregivers who display minimal intrusiveness. There is

some evidence of intrusiveness, but it is not typical. The mother may initiate interactions with and offer suggestions to the child which occasionally are not welcome or ill timed.

3 = Moderately characteristic. This rating should be given to mother who are often intrusive/overcontrolling. Mother intrusiveness occurs in some interactions at a fairly high level, but are often totally absent; or moderately intrusive/controlling behavior is evident more often; or for mothers who rarely interact, a substantial proportion of their interactions are intrusive.

4 = Highly characteristic. This mother's interactions with the child are consistently and typically intrusive. During their interaction, the mother controls the interaction, allowing the child little self-direction in his/her activities. During the time that they are interacting, the mother allows the child little autonomy, and essentially negates the child's experience.

Detachment/Disengagement/Undercontrol (adapted from Fish, 1990 and Arnett)

The detached/disengaged/undercontrolling mother appears emotionally uninvolved or disengaged, and unaware of the child's needs for appropriate interaction to facilitate involvement with objects or people. This mother does not react contingently to the child's speech, play or other actions, and does not provide the interpersonal support or "scaffolding" which would enable the child to expand his behavioral repertoire and activities. Thus, there is little joining in the child's play, participating in conversation, or even awareness of what the child is doing. Detached caregivers "miss" the child's bids to them, signals of frustration or difficulty in goal-directed behavior, and initiations or escalations of peer conflict. Moreover, when mothers do get around to interacting with the child, their timing is often out of synchrony with the child's affect and responses (although not with the overwhelming barrage of stimulation that intrusive mothers present). Simply allowing the child to play by him/herself is not necessarily a sure sign of detachment; this can be appropriate at times, such as when the child is playing happily or contentedly and the mother checks in with the child visually. This is especially true of toddlers and preschoolers who must be given time, space, and independence to explore the object and social worlds. The detached/disengaged/under-controlling mother lacks the emotional involvement that characterizes a sensitive mother. He/she appears uninterested in the child, the child's activities, and the child's successes, failures, and struggles.

During the toddler and preschool years, detached/under-controlling mothers often evident in the disciplinary encounters that do NOT take place or in the insufficiency of those that do occur. Detached/under-controlling mothers often fail to act when potentially dangerous situations arise or when peer conflicts get out of hand or when the child is doing something that s/he has been told s/he should not be doing. At the extreme, detached/under-controlling mothers simply fail to monitor the appropriateness of child behavior so that they can step in when some kind of discipline or adult control is called for. It may also be the case that detached/under-controlling mothers simply fail to follow through with their stated intents (e.g., tell a child he will get a time out if he does a particular action again, but then failing to give the time out when the action re-occurs) or do so in a too-limited or inconsistent manner (e.g., instead of giving the time out, repeat the warning; start to give the time out, but then get distracted).

A mother receiving a high rating for detachment/disengagement/under-control is considered to be insensitive. A low rating for detachment can signal either sensitivity or intrusiveness.

Detachment can be marked by (a) the child being out of sight of the mother for extended periods without the mother checking in to see what the child is up to; (b) rarely being involved with the child in play, learning or conversation; (c) failing to respond to the child's approaches, vocalizations, smiles, or other social bids; (d) evident lack of awareness of the child's engagement in inappropriate behavior; (e) failing to respond to behavior and situations that call for adult regulation of child experience or responding half-heartedly and inconsistently, (f) permitting long stretches of unoccupied time or wandering without directing the child to an activity; (g) ignoring the child's difficulties with the physical environment, especially where such difficulties are emotionally stressful for the child, e.g., problems with handling a spoon, problems getting dressed, problems getting blocks to stack, etc. (The sensitive mother permits the child ample opportunity to try to solve the problem by herself, stepping in when necessary to prevent too much frustration or disappointment; the intrusive mother steps in too soon, never allowing the child the autonomy to try to solve the problem himself; the detached mother doesn't step in at all, or only when the child is so distressed that it cannot be ignored); and (h) says, or conveys nonverbally, "don't bother me; stay out of my way; leave me alone." Some detached mothers place an overemphasis on the physical setting and other adults (e.g., visiting with other mothers, filling out forms, straightening the room) instead of attending to the child.

This scale contains both qualitative and quantitative components. A mother who interacts consistently with the child but does so in a perfunctory or indifferent manner with little or no emotional involvement would be rated high on detachment. Note, too, that a mother who is generally emotionally involved but who fails to assert appropriate regulatory controls and thus may be regarded as permissive from the standpoint of discipline would receive more than a rating of one for detachment. In some cases, the extent of child behavior that merits efforts by the mother to control and regulate it but which go uncontrolled and unregulated by mother determines how high the rating will be.

1 = Not at all characteristic. This rating should be given to mothers who display no signs of detachment or underinvolvement. When interacting with the child, the mother is clearly emotionally involved. And when not interacting with the child these mothers are aware of what the child is doing. These mothers can be sensitive or intrusive.

2 = Minimally characteristic. This rating should be given to mothers who display minimal detachment while the mother is sometimes noninvolved, he/she is clearly more involved than not.

3 = Moderately characteristic. This rating should be given to mothers who are mostly detached. The mother is unaware of what the child is doing and where s/he is at fairly often.

4 = Highly characteristic. This rating should be given to mothers who are highly detached. The child spends virtually all of his/her time without mother attention, or at best only visual attention. In the minimal instances of involvement, the mother's behaviors are simple, mechanical, stereotyped, repetitive, and perfunctory. The mother is clearly not emotionally involved with the child, and appears to be "just going through the motions."

Stimulation of Cognitive Development

This scale measures the degree to which the mother tries to foster the child's cognitive and mental development. A stimulating mother may take advantage of even simple activities (eating, dressing, potty) to stimulate development, and will consistently engage in a variety of activities that can facilitate learning. The mother will make deliberate attempts to encourage the child's development, achievement, and learning.

Behaviors characterizing stimulation include (a) attempting to focus the child on an object or task; (b) focusing the child's attention on the unique attributes and perceptual qualities of objects (i.e., their colors, how they move, what they can be used for); (c) suggesting more sophisticated play activities (e.g., "what if you tried..."); (d) verbally responding to and expanding on the child's verbalizations or vocalizations; and (e) encouraging the child to actively participate in activities. However, mothers who simply focus or encourage a child should not be given the highest scores. Higher scores should be reserved for those mothers who (a) describe, label, or ask questions about toys or objects, or demonstrate how they work; (b) stimulate the child's speaking and expand on their verbalizations; (c) read or recite to the child; (d) encourage and reinforce the child's attempts at mastery, or challenge the child to try something new; (e) present activities in an organized sequence of steps; (f) teach the child or give him/her an opportunity to experiment with materials that illustrate or teach concepts; (g) ask questions that require problem solving; (h) label and interpret the child's experiences, (e.g. "You think that's funny"); and so on.

Activities involving strictly physical stimulation such as rough and tumble play, bouncing, and tickling are not considered as stimulating development in terms of this rating. Nor do those activities that are only social (hugging or smiling) or caretaking (soothing) qualify as stimulation of development in terms of this rating scale.

The focus of this scale is on the amount and quality of activities that may ultimately enhance perceptual, cognitive, linguistic, and physical development. Simply placing objects in front of a child or handing him/her toys is not to be considered stimulating. Stimulation must involve effortful interaction with the child in the contexts described above.

All qualitative judgments must be considered in relation to the quantity of stimulation provided by the mother: How many of the available opportunities for stimulation were taken advantage of? A rating of 1 should be given to those mothers who provide almost no stimulation of development. If a mother spends a brief portion of the time in very cognitively stimulating interactions with her child but provides no cognitive stimulation for the remainder of the time, she would receive a rating of 2. A mother might also receive a 2 for several instances of lower level stimulation. A rating of 4 should be given to those mother who work at providing exceptionally advantageous stimulation in terms of language and object manipulation. This is not a rating of the sensitivity with which the cognitive stimulation is provided but purely the quantity and variety of cognitive stimulation as described above.

1 = Not at all characteristic. The mother makes almost no attempts to teach the child anything or provide any stimulation. He/she may provide routine care but does not use it as an opportunity for learning. The mother may ignore the child's activities or interact perfunctorily, providing no stimulation.

2 = Minimally characteristic. This rating should be given to mothers who provide infrequent or weak stimulation. The mother's conscious and purposeful attempts to engage in development-fostering experiences are limited. He/she may label or demonstrate materials, but does so perfunctorily and/or with minimal elaboration.

3 = Moderately characteristic. This rating should be given to mothers who provide adequate stimulation but could reasonably be expected to provide more and higher-quality stimulation. The mother does make some effort to provide stimulation, but does not consistently take advantage of opportunities to do so. Stimulation is not the main agenda. The mother may find some new ways to engage the child with toys, for example, but these ways are limited in number. Actions are likely to be simply repeated rather than thoughtfully varied. Mothers who provide a rich linguistic

environment but do not demonstrate the potential of toys or objects would receive this rating.

4 = Very characteristic. This rating should be given to the mother who is consistently stimulating and takes advantage of many activities as opportunities for stimulation. The mother provides frequent stimulation through "lessons," explanations, activities, or toys. Teaching or fostering development is a primary intent of the mother's frequent interactions with the child. The mother thoughtfully varies and elaborates on these activities, providing numerous opportunities which are exceptionally advantageous to the child. He/she provides rich stimulation in terms of language, and embellishment of the potential of the physical world.

Positive Regard for the Child

This scale rates the mother's positive feelings toward the child, expressed during interaction with him/her. Positive feelings are shown by (a) speaking in a warm tone of voice; (b) hugging or other expressions of physical affection; (c) smiling; (d) laughing with the child; (e) enthusiasm about the child; (f) praising the child; and (g) general enjoyment of the child. Positive regard is evident when the mother listens, watches attentively, looks into the child's face when talking to him/her, has affectionate physical contact, and is playful.

Ratings on this scale are based or both quality and quantity of positive regard.

1 = Not at all characteristic. This rating should be given to mothers who display no positive regard. This rating can also be used for positive expressions (laughing, smiling) that appear to be inappropriate to the situation or an inaccurate reflection of the mother's feelings. The mother may be expressionless or flat, or negative.

2 = Minimally characteristic. This rating should be given to mothers who display infrequent or weak signals of positive regard. The intensity or frequency of behavior indicators are very low.

3 = Moderately characteristic. This rating should be given to mothers who typically display positive regard. This rating should be given to mothers who typically display positive regard. More frequent and intense positive affect is shown than in the 2 rating, but the mother is not as consistently positive as those scored as a 4.

4 = Very characteristic. This rating should be given to mothers who are exceptionally positive, in terms of facial and vocal expressiveness, and behavior. Affect is positive, spontaneous, and frequent. The mother shows a range of expressions and behaviors which are all clearly positive. He/she clearly "delights" in the child.

Negative Regard for the Child

This scale rates the caregiver's negative regard for the child. Both frequency and intensity of negative affect toward the child are considered. Some markers of negative regard include (a) disapproval; (b) tense body; (c) negative voice when correcting; (d) abruptness; (e) tense facial muscles and strained expression; (f) harshness; (g) threatening the child or punishing without explanation; and (h) roughness when providing basic care and handling. In toddlers especially, autonomy and noncompliance bids may elicit anger or rough handling. These are indicative of negative regard for the child. However, in toddlers not all angry expression by the mother is negative regard. For example, if the child intentionally breaks a toy, and the mother says "That makes me angry when I see you breaking your toys" with an angry voice, that is an appropriate affective message and does not indicate negative regard for the child. Hence this scale gets at anger that is inappropriate in cause or in intensity. If the mother blows up when a child knocks over a toy by accident, or abruptly jerks a child, that is inappropriate anger. Remember, this scale measures negative regard for the child, and not negative affect alone.

Ratings on this scale are composed of both qualitative and quantitative evaluations. The amount and intensity of negative regard exhibited is evaluated in relation to the duration of the observation period.

1 = Not at all characteristic. This rating should be given to mothers who do not display negative regard for the child either in words or in expressions. No evidence of anger, distrust, frustration, impatience, disgust, general dislike, or other indicators of negative regard is observed in the mother's face or voice. The mother may be expressionless or flat, or positive.

2 = Minimally characteristic. This rating should be given to mothers who display minimal negative regard. There is some evidence of low-intensity negative regard.

3 = Moderately characteristic. This rating should be given to mothers who regularly display negative regard. Multiple instances of low-intensity negative regard or some evidence of more-intense negative regard is observed.

4 = Highly characteristic. This rating should be given to mothers who are extremely negative. Feelings of negative regard are expressed strongly and repeatedly, or persistent moderate levels of negative regard are expressed. The overriding affect influencing the mother-child interactions is negative.

Flatness of Affect

This scale measures how animated the mother is with the focal child and others in the room. Flat affect may reflect boredom, depression, fatigue, or distraction. Flatness is exhibited by blank, impassive facial expression, and flat tone in vocal expression. It is marked by a lack of animation. If the mother is watching the child with interest (eyes "bright"), it is a sign that the mother's affect is not flat. This scale assesses the caregiver's overall demeanor, not just animation with the target child.

1 = Not at all characteristic. This rating should be given to mothers who exhibit almost no flatness. The mother's demeanor and behavior are consistently animated.

2 = Minimally characteristic. This rating should be given to mothers who exhibit some flatness. The mother is usually animated, but there are occasions when facial expression and/or voice is blank and impassive.

3 = Moderately characteristic. This rating should be given to mothers who are mostly flat. The child exhibits several instances of strong positive affect (expresses enthusiasm, playfulness, smiling, and laughter) and is often pleasant.

4 = Highly characteristic. This rating should be given to mothers who are consistently. There is consistent absence of animation.

B. Child Ratings

Positive Mood

This scale assesses the extent to which the child is satisfied, content, and pleased with the situation overall. Measures of child positive affect include smiles, laughter, and positive tone of voice, as well as enthusiasm expressed with arms, legs, and body tone. Lack of positive affect may be manifested by a neutrality or negative mood.

Ratings on this scale should be based on quality and quantity of behavior. Attempt to balance both the intensity of the child's positive affect and the relative amount of time positive behavior is shown. A rating of 1 should be given to those children who exhibit no positive affect and give no evidence of feeling good. If a child spends a very brief portion of the time exhibiting moderately high positive affect (e.g., 1-2 smiles), he/she would receive a rating of 2. A child might also receive a 2 rating for weak positive affect expressed continuously (i.e., contentment/pleasant expression). A rating of 3 is given to a child who is content and pleasant throughout the observation period and expresses strong positive affect on several occasions. A rating of 4 should be given to those children who regularly display high-intensity positive affect. Those rated 4 appear to "sparkle."

1 = Not at all characteristic. This rating should be given to children who display no signs of positive mood. The child provides no real indication of being happy, content, or in a pleasant state.

2 = Minimally characteristic. This rating should be given to children who display infrequent or weak positive affect. The child may show brief instances of strong or moderately strong positive affect, or the child may be characteristically pleasant, content or satisfied throughout

the observation period, without exhibiting any strong indicators of positive mood.

3 = Moderately characteristic. This rating should be given to children who frequently display positive affect. The child exhibits several instances of strong positive affect (expresses enthusiasm, playfulness, smiling, and laughter) and is often pleasant

4 = Highly characteristic. This rating should be given to children who are exceptionally positive, in terms of physical and vocal expressiveness. The child displays multiple instances of strong positive affect and is characteristically "pleasant" for most of the remainder of the observation period. The child should truly "radiate" or "sparkle." For this rating, a child can have no episodes of strong distress.

Negative Mood

This scale assesses the extent to which the child cries, fusses, frowns, yells, screams, or tenses body while crying, or otherwise expresses his/her discontentment. Lack of negative affect may be manifested as either strong positive affect or contentment.

Ratings on this scale should be based on both qualitative and quantitative assessments.

1 = Not at all characteristic. This rating should be given to children who display no negative affect. There are no

signs of strong (intense crying, body stiffening) or weak (fussing) negative affect from the child during the observation period. A "1" may also be scored if a single mild fret occurs.

2 = Minimally characteristic. This rating should be given to children who display infrequent or weak negative affect. The child displays brief instances of mild negative affect.

3 = Moderately characteristic. This rating should be given to children who display strong and/or frequent negative affect. The child displays one or two instances of modestly strong negative affect or is moderately discontented (fussy, whining) throughout most of the observation period.

4 = Highly characteristic. This rating should be given to children who display high levels of negative affect. The child displays several instances of strong negative affect during the observation period and appears to be rarely contented.

Activity Level

This scale assesses how motorically active the child is during the observation. The rating should take into account these aspects of motor activity: speed (moving fast, whether walking, crawling, or squirming); frequency (spending a lot of time in high energy activities); intensity (how energetic the activity); involvement (tendency to engage in high-energy games and gross motor activities over small motor activities); and a negative reaction to enforced nonactivity (reacting with restlessness).

1 = Not at all active. This rating should be given to children who are noticeably low key, passive, inactive, lethargic. The child typically stays in one place.

2 = Minimally active. This rating should be given to children who are minimally active. The child exhibits some activity.

3 = Moderately active. This rating should be given to those children who are predominantly active. High-intensity activity occurs a few times or the child is less intensely active for most of the observation session.

4 = Highly active. This rating should be given to children who are overwhelmingly active. The child is constantly moving some body part; something is moving at all times. The child prefers active games and activities to nonactive ones.

Sustained Attention with Objects

This scale assesses children's sustained involvement with the world of objects. The child's attention does not jump from one thing to another quickly. The child spends more than a minimal amount of time focusing on the object he/she is in contact with. When focusing on an object the child really "focuses in." The uninvolved child may appear apathetic, bored, distracted, distressed, or aimless.

The focus of this scale is primarily quantitative. Ratings are based primarily on the duration of interactions with objects, and the overall amount of time spent in these interactions.

1 = Not characteristic. This rating should be given to children who display no sustained attention. The child moves from one thing to another in a nonsystematic way, without seeming to focus on what the objects have to offer.

2 = Minimally characteristic. This rating should be given to children who can sustained attention for only brief periods or for only a limited proportion of the observation period.

3 = Moderately characteristic. This rating should be given to the child who spends more than the minimal amount of time involved in interactions with things. There are a few extended bouts of focussed attention or brief bouts occur often.

4 = Highly characteristic. This rating should be given to the child who is clearly involved, interested, and focused most of the time. When the child is playing with objects he/she is interested in playing with them and is engaged for extended periods of time.

Child's Engagement with Mother (adapted from Booth, 1991)

This scale assesses the extent to which the child is socially connected to the mother. Behaviors indicative of engagement include (a) positive responding to the mother's initiation of a play activity (attending to the mother's suggestions or demonstrations of an activity, and following her lead by adopting that activity of incorporating an offered object into ongoing play); (b) initiating play that includes the mother (by offering/showing an object, requesting help, etc.); (c) positioning/orienting body toward the mother, and (d) sustained attention during interaction or play with the mother. Behaviors indicative of disengagement include (a) active rejection of mother's play overtures (by pushing offered objects away, ignoring the mother); (b) engaging in self-occupied play that excludes the mother; (c) positioning/orienting body away from the mother.

Ratings on this scale should be based on both quality and quantity of behavior.

1 = Not at all characteristic. This rating should be given to children who display no engagement with the mother. Children given this rating seem clearly disconnected and disengaged. They actively reject or ignore the mother's efforts to engage them and/or initiate no such efforts on their own.

2 = Minimally characteristic. This rating should be given to children who display infrequent or weak engagement. These children are somewhat responsive to mother, but not in a sustained way. Brief periods of engagement may occur. Play appears self-occupied -- typically it excludes the mother although active rejection also may be present.

3 = Moderately characteristic. This rating should be given to children who are more engaged with the mother than not. The child initiates and/or responds but the intensity and/or frequency of the child's behavior is less than a 4.

4 = Highly characteristic. This rating should be given to children who are very engaged with the mother. The child has a high frequency of initiations that include the mother and/or positive responses to the mother's initiations. Sustained play with the mother is observed.

ATTACHMENT ORGANIZATION IN PRESCHOOL CHILDREN: PROCEDURES AND CODING MANUAL

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These guidelines are the result of a collaborative effort among many people. Much of what is included here was discussed, revised, and refined at the 1986, 1987, and 1988 workshops hosted by the Seattle Node of the John D. and Catherine T. MacArthur Network on the Transition from Infancy to Early Childhood. Working sessions entailed theoretical discussions as well as extensive viewing and discussion of videotaped separation and reunion situations from several laboratories. Mary Ainsworth, not only during the workshops but also throughout the development of this system, has been a particularly valuable mentor and colleague. Her contributions, as always, have improved the quality of these guidelines.

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INTRODUCTION

These guidelines present a system for assessing quality of attachment in preschool children between the ages of 2 1/2 and 4 1/2. Assessments are made on the basis of the child's behavior on separation and reunion with the attachment figure in a laboratory setting.

Purpose of the report

The purpose of this document is to provide attachment researchers with procedural suggestions and coding guidelines for behavioral assessment of child-parent attachment in 2 1/2- to 4 1/2-year-old children. We wrote this manual with the assumption that the reader has had extensive training and experience coding infants in Ainsworth's strange situation (Ainsworth, Blehar, Waters, & Wall, 1978). We have omitted a great deal of information that would be necessary for the sake of clarity and coherence if the reader lacked this experience. We do not assume extensive familiarity with Main & Cassidy's (1988) sixth-year system, but refer to it occasionally because it may be of interest of those familiar with that system, and to point out (a) how we used that system in the construction of the present one, and (b) the coherence of the three systems for observing reunion behavior across various ages.

Training and Reliability

It has been our experience that it is more difficult to assess attachment quality in young children than in infants, and that it generally requires as long as two hours of coding time. It has also been our experience that the amount of training required to code reliably the quality of attachment of older children is considerably greater than that required to code the quality of attachment of infants. Researchers who wish to use this system should contact either Jude Cassidy, Bob Marvin, or Sue Spieker for training information. Study of this manual alone is not sufficient for learning the coding system. Videotapes should not be classified using this system without training, which consists of careful viewings and review of many (60+) videotapes with intensive instruction from a qualified coder. An acceptable level of agreement with a MacArthur group reliability tape is also required. In addition, because feedback from researchers using this coding system will insure its continued growth and improvement, we request that researchers who do use these guidelines provide Jude Cassidy or Bob Marvin with feedback on their experiences. Finally, we request that publications using this system include mention of where coders were trained.

Organization of the report

This report is divided into three sections. In the first, we discuss the rationale underlying the development of the coding system, and the procedures used in this development. In the second section, we present two procedures for use with this system, and discuss a number of procedural considerations. Finally, in the third section, we present the coding system: beginning with the classificatory groups and continuing with the scales for rating security and avoidance.

A list of studies which have used this attachment coding system is included here as Appendix X.

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SECTION I: RATIONALE AND DEVELOPMENT

Rationale underlying the development of the coding system

Principal guiding assumptions

An important guiding assumption has been our belief in the existence of what Main and her colleagues (Main, 1981; Main & Weston, 1982; Main, Kaplan, & Cassidy, 1985; Main & Solomon, 1986) have referred to as "strategies" associated with each of the three basic attachment patterns. The concept of "strategies" refers to each individual's attempts to maintain a particular organization in relation to attachment. These strategies are outlined in Appendix I.

There is considerable support for the notion that these strategies underlie the three basic attachment patterns not only in infants, but also in older children (ages 5-7) and adults – both at the behavioral and representational levels (Ainsworth et al., 1978; Belsky, Rovine, & Taylor, 1984; Cassidy, 1988; Cassidy & Main, 1984; Kaplan 1987; Kobak & Sceery, 1988; Main & Goldwyn, 1984; Main & Cassidy, 1988; Main et al., 1985; Wartner & Grossmann, 1988). Of course, the specific behaviors associated with these attachment patterns vary greatly across developmental level, but the underlying organization remains quite similar.

Given such consistency of underlying organization across several levels of development and several levels of assessment, we reasoned that it was theoretically expectable for the attachment organization of 2 1/2- to 4 /1/2- year-olds to be similarly consistent with that of individuals at other ages. Therefore, we looked for patterns of behavior that reflected these attachment organizations, patterns that meshed with patterns described in previous attachment literature. For example, based on the existence of avoidant attachment patterns in infants, six-year-olds, and adults, we expected a similar pattern in three-year-olds. Although we were unsure of the specific behavioral manifestation, we expected behaviors consistent with the underlying strategies of seeking to limit intimate, personal, and affective interchanges. The pattern shown by infants classified insecure/avoidant (pattern A) is strikingly similar to that shown by six-year-olds classified insecure/avoidant: children at both ages avoid intimate interaction or contact, maintain an affective neutrality, and convey the impression that the parent's return is of no particular importance to them.

Similarly, we anticipated the emergence of a secure pattern consistent with an underlying strategy of using the attachment figure as a secure base from which to explore. The pattern shown by infants classified securely attached (pattern B) is strikingly similar to that shown by six-year-olds classified securely attached: children at both ages show interest in proximity or at least interaction with the attachment figure. The special relationship with the parent serves as a basis for exploration. (In relation to both of these attachment patterns, the "striking similarity" is in terms of underlying organization; the specific behaviors are obviously different at the two developmental levels.) Because of the similarity across ages of the behavioral manifestations of these two attachment organizations, we hypothesized similar behavioral manifestations for these two attachment patterns at ages 2 1/2 to 4 1/2. At the same time, however, we remained open to the possibilities that at this intermediate age, attachment organization could be manifested in entirely different ways, or that patterns might emerge that were different from those theoretically expected.

The third of the basic attachment patterns identified in the Strange Situation in infancy (insecure/ambivalent, pattern C) was also identified in six-year-olds by Main & Cassidy. However, in this case, there was substantial shift from infancy to early childhood in the behavioral manifestations associated with the attachment pattern. Insecure/ambivalent infants are characterized by ambivalence to physical proximity/contact, angry resistance (including full-blown temper tantrums), little or no avoidance, and in some instances, extreme passivity. At six, children classified in this group still show ambivalence to physical proximity or contact, but no longer show the angry resistance or passivity, and show moderate avoidance. They may also show immature "babyish" behavior, emphasizing their dependence on the parent. This shift raised several questions: When does this shift occur? Would there be a group of children who, at this intermediate age, showed behaviors similar to infants? Would there be a group of children who showed behaviors similar to six-year-olds? Would there be a group of children who showed both sets of behaviors? Would neither set of behaviors be shown at this age? [It is interesting to note that Vaughn and his colleagues (Vaughn, Egeland, Sroufe, & Waters, 1979) reported that over 20% of infants classified ambivalent at 12 months were classified avoidant at 18 months. Main & Cassidy (1988) have pointed out that although these shifts may reflect true changes in attachment quality, it is also possible that these shifts in classification reflect an increased presence of avoidance as a component within the ambivalent classification itself.]

A fourth group of infants identified in Ainsworth's strange situation have been classified "insecure/disorganized-disoriented" (category D; Main & Weston, 1981; Main & Solomon, 1986). These infants have presented a special case. Main & Solomon (1986) have referred to these infants, as compared with other infants, as having no consistent strategy for dealing with the attachment figure. Evident in the reunion of these infants were "dazed behavior, disordering of expected temporal sequence, incomplete movements, simultaneous display of contradictory behavior patterns, undirected affective expression, and termination of movements in postures suggesting depression, confusion, or fear." Main & Hesse (1990) have hypothesized that these behaviors may result from a relationship in which the parent either frightens the child or is frightened herself (which would in turn frighten the child). In the Berkeley sample, 9 of 12 children (75%) classified in infancy as disoriented/disorganized were classified at age six as insecure/controlling. On reunion at six, these children sought to take control of the relationship, either through hostile, punitive manipulations, or through subtle, helpful guiding and caretaking behaviors. Main & Hesse (1990) have proposed that the "disorganization in the infant [may be] reflective of the disorganization in parental caregiving strategies, and [that] developmental changes [occur] over time such that the initially disoriented and disorganized infant comes to assume a somewhat parental role within the parent-child relationship." It is possible that this need to control develops "out of a need to care for or control a parent whose own caregiving strategy had been disorganized by loss or by other traumatic events" (Main & Hesse, 1990).

Thus, between the ages of one year and six years a considerable shift has occurred in the behavior of this fourth group of children. Children who were formerly disorganized and/or disoriented have become quite organized -- organized in controlling the parent. (It may be that it is the relationship that has become disorganized at age 6, in that the ordinary family structure, with the parent in control of the child, has become reversed; see Marvin & Stewart, 1990.) It is as if a child who cannot count on the parent for structure steps in and provides structure (takes control). Again, in terms of the the present system, a number of questions arose: When does this shift occur? Would there be a group of children who, at this intermediate age, appeared disoriented/disorganized, as there is with infants? Would there be a group of children who controlled the parent, as there is with six-year-olds? Would there be a group of children who showed both sets of behaviors? Would neither set of behaviors be shown at this age?

Caveat: The establishment of reliable means for classifying the organization of attachment behavior in a laboratory setting cannot, of course, speak to the theoretical assumption that such classifications reflect the history of the child's attachment experiences with that attachment figure. The validity of this basic assumption can only be examined in subsequent studies of the relation between "real life" events and the pattern established via the classification. For instance, we may find that 30 out of 40 children who had been secure as infants show a particular pattern at age three, this pattern may mesh with patterns identified as secure in both infancy and age six, and it may mesh with a working model of using the parent as a secure base from which to explore. But if home observations reveal that most of these 30 children experience rejecting, interfering, and unavailable caregivers in the home, we would need to consider that pattern of reunion behavior as reflective of insecure attachment in three-year olds.

The ideal procedure for the development of a system for classifying attachment would include a sample of children for which there were extensive home observations of parent-child interactions. In that case, decisions about security/insecurity of attachment could be made based on home observations. Patterns of laboratory reunion behavior could then be linked with home observations, providing a measure of the validity of our reunion rating system. For instance, if children who had home experiences of a rejecting, unavailable caregiver tended to show reunion behavior "x," we could assume a connection between insecure attachment and " x-type" reunion behavior. Conversely, if a certain group of children looked similar on reunion with the parent, we might examine the home experiences of this group in order to identify common experiences. This procedure is similar to that used by Ainsworth with her Baltimore sample of infants in the development of the Strange Situation. Unfortunately, we have not, as yet, had access to such a sample.

We have not felt it necessary to wait for a sample which includes home interaction data before beginning work. A great deal of recent theoretical and empirical work in the attachment field served to guide us. We propose here a system for coding quality of attachment in 2 1/2- to 4 1/2-year-olds based on the child's behavior related to separation and reunion in a laboratory setting. A critical future test for this system will be the extent to which it serves as a reflection of various attachment-related experiences experienced by children in the home on a daily basis.

Additional Considerations

Patterns of attachment. Ainsworth (1978), Waters (1978), Sroufe and Waters (1977), and Main (Main & Cassidy, 1988; Main & Solomon, 1986; Main & Weston, 1982) have all stressed the importance of focusing not on discrete behaviors but on the organization of those behaviors, the importance of examining patterns of attachment.

This belief is also central to the present system. We stress again that we consider not only the frequency of discrete behaviors, but also context, timing, quality, and patterning. The presence or absence of any single behavior or any set of behaviors does not determine attachment classification. The existence of particular patterns across the situation as a whole determines attachment classification.

[Note: Cummings (1990) has developed another coding system with an emphasis on patterns of attachment which is applicable to children this age (and which may be applicable more generally). His approach focuses on an organizational interpretation of behaviors relevant to judgement on a security-insecurity continuum. Cummings uses a 4-point scale that includes the following categories: secure, insecure, very insecure, and not attached. Children coded very secure evidence optimal functioning of the attachment behavioral system in stress contexts; that is, the child has easy emotional and physical access to the attachment figure, and contact or interaction is effective in ameliorating stress. Children coded very insecure show very strong and general signs of difficulty in deriving security from the attachment figure, as shown by multiple problems of avoidance, resistance, difficulty comforting, depressed affect, conflicted behavior, or disconnected behavior.]

Coding parental behavior and/or the dyad vs. coding the child's behavior. Ainsworth's strange situation is coded by considering only infant behavior. Parental behavior is, in fact, strictly constrained by precise instructions to the parent, and the resulting range of parental behaviors is limited. Similarly, in Main & Cassidy's (1988) system for coding attachment in 6-year-olds, only child behavior is used as a basis of classification. Main & Cassidy's procedure differs from Ainsworth's in that parental behavior is not constrained at all: parents are given no instructions, and the range of parental behavior is naturally much broader. The present system follows the pattern of these two earlier systems and deals only with child behavior.

Although this system does not code parental behavior, it does consider parental behavior to the extent that it recognizes that parental behavior provides a context within which child behavior is examined. There are at least four ways in which this consideration is important:

First, different child behaviors can have the same meaning, depending on the context of parental behavior. We believe, as Main & Cassidy (1988) have suggested, that although the child's specific behaviors may change as a function of parental behavior, the global strategy underlying the behavior remains the same. Children classified avoidant, for instance, are viewed as having a strategy of limiting interaction with the parent and maintaining neutrality. A child can maintain neutrality by playing silently if the parent sits quietly across the room and suggests no interaction. But, on the other hand, the child must make at least minimal responses in order to avoid a confrontation if the mother presses repeatedly for interaction. Thus, the child can be viewed as remaining flexible and finding the necessary set of behaviors that, under the circumstances and within the context of the parent's behavior, will enable him to carry out his desired strategy.

Second, the same child behaviors have different meanings depending on the context of parental behavior. The child's sitting with the back to the parent and not speaking is avoidant if the parent is sitting quietly across the room, and punitive if the parent is close to the child and repeatedly asks direct questions.

Third, different parental behaviors may yield the same sets of behaviors from different children. For instance, one parent may approach the child and initiate play, and the other may move, on entrance, to the far side of the room and sit quietly. Both sets of parental behaviors, however, may yield full initiating and responsive secure reunion behavior.

Fourth, the same parental behaviors may yield different sets of behaviors from different children. For instance, consider the parent who moves up quite close to the child and actively tries to engage him in conversation. The child who responds to this easily and fully is classified secure. The child who quietly limits conversation, who seems nervous with the proximity, who strongly averts his gaze, and/or who tries to move away is classified avoidant. Similarly, consider the parent who enters the room, gives a brief greeting, and sits across the room from the child. The child who initiates fluid and personal conversation and (perhaps) approaches the parent is classified secure. The child who continues play, perhaps while turned away from the parent, and gives no indication that the return of the parent has any meaning for him is coded avoidant

In order to maintain comparability with previous attachment classification systems, we have chosen to examine both child and parental behavior, but to classify on the basis of the child's behavior only. We assume that the parent's reunion behavior may be more reactive to the experimental setting than is the child's, and that such brief shifts in parental behavior are not be sufficient to cause the child to shift his relatively stable strategy in relation to the attachment figure. This remains, of course, an empirical question.

Given that parents have working models of relationships and strategies for dealing with attachment issues just as children do (e.g., Bowlby, 1980; Main & Goldwyn, 1984), it is logical to expect parents to behave in ways reflective of these working models (just as children do), and for parents to organize their behavior in the service of their underlying strategies (just as children do). Further, given that a parent and child share an ongoing relationship, they may have complementary working models of that relationship. It is not surprising that child and parent behavior often present a coherent, complementary whole (Marvin & Stewart, 1990). The child who is caregiving to the parent often has a parent who acts childlike and "pulls" for caregiving. The child who is responsive and initiating often has a responsive, warm, non-intrusive parent. This, of course, is not always and not necessarily so. It is likely that over the long run it is the dyad that maintains the stability within the relationship, with shifts by one member being regulated by the behavior of the other. Whether or not parental behavior within this brief laboratory situation provides accurate information about the parent's ongoing relationship with the child remains to be seen.

Appendix II describes some of the patterns of parental behaviors that we have observed.

Reunions and separations. Information for classification comes from pre-separations, leave-takings, separations, and reunions. However, as with Ainsworth's infancy strange situation, predominant emphasis is placed on reunion behavior. Our use of reunion behavior is based on a belief that reunion can be an important moment in a relationship: an emotionally heightened time, a time of re-establishing the relationship. This belief rests on previous studies in which the examination of reunion behavior has yielded important information about relationships. Previous studies have examined: reunions of young children with their mothers following long-term naturally occurring separations (Robertson & Bowlby, 1952), reunions of infants to parents in Ainsworth's strange situation (Ainsworth, Blehar, Waters, & Wall, 1978; see Bretherton, 1985 for a recent review), reunions of 2-, 3-, and 4-year-olds to mothers in a laboratory setting (Marvin, 1977), reunions of six-year-olds to parents following a one-hour laboratory separation (Main & Cassidy, 1988; Solomon, George, & Ivins, 1987; Wartner & Grossmann, 1988), reunions of infants to mothers in the home (Stayton & Ainsworth, 1973), reunions in daycare settings (Field, 1982; Sheldon, Thompson, & Earl, 1985), and reunions between married couples at the end of the day (Gottman, 1979). Taken together, these studies of reunions in both laboratories and natural settings involving subjects of various ages suggest that reunion behavior can serve as a reflection of underlying aspects of relationships. These studies also reveal that particular patterns of reunion behavior are related to particular and coherent forms of functioning, and that different insecure patterns of reunion behavior are related to different forms of problematic functioning. It is with this large body of convergent data as a backdrop that we suggest that examination of the behavior of 2 1/2- to 4 1/2-year-olds on reunion with their parents may offer important insights into the nature of those relationships.

Separation behavior has also provided an important source of data (e.g., Stayton & Ainsworth, 1973; Cassidy & Main, 1985). As children get older, the ability to tolerate brief separations from parents becomes an important developmental accomplishment. With six year-olds, Cassidy & Main (1985) reported that significantly more six-year-olds who had been insecure in infancy showed distress during a one-minute alone period than did children who had been securely attached to mother. Nonetheless, separation has generally revealed substantially less information about quality of attachment than reunions (even though the Ainsworth strange situation was originally designed to examine separations). In the strange situation, infants showing identical behavior on separation can be given very different attachment classifications. In addition, two recent studies have supported the notion of the greater usefulness of reunions (vs. separations) in tapping quality of attachment. Suomi (1987), working with a sample of rhesus monkeys raised by foster mothers, found that whereas the infant's response to separation was predicted more by the infant's genetically determined "reactivity," the infant's response to reunion was determined more by the foster mother's quality of mothering --

particularly sensitivity vs. insensitivity and acceptance vs. rejection. Similarly, Belsky (Belsky & Rovine,1987) found a high concordance across parents of what can be viewed as the infant's degree of reactivity (i.e., A1 to B2 vs. B3 to C2 subgroups), but found independence across parents of the infant's security of attachment (i.e., secure vs. insecure). Belsky has proposed that these findings suggest that separation behavior may be more influenced by infant characteristics, and reunion behavior may be more influenced by the quality of the dyadic relationship.

A wide range of behavior during separation has been observed in the 2 1/2- to 4 1/2-year-olds we have examined, including continuous active play, stopping of play and quiet waiting, crying, attempts to engage the stranger, active search, aimless wandering, self-comforting behavior, and standing by the door. In relation to separation behavior, most 2 1/2- to 4 1/2-year-olds are truly in between infants and six-year-olds: in general, tolerating separation more easily than the former but with more difficulty than the latter. These children are similar to infants in that they are still challenged by separation from the attachment figure; they still use attachment figures as a secure base in a rather concrete fashion. Yet they differ from infants in that by 3, most children do not mind being left as long as there is another available adult present. They do not like being left alone, as opposed to infants who more often do not like being left without the parent. (See also, Marvin, 1977.) It should be noted that this description refers to group trends and not all individuals. In fact, some 2 1/2-year-olds seem completely or nearly completely at ease during the parent's absence, whereas some 3-year-olds seem relatively upset during the parent's absence. Particular care must be taken since this classification system covers a broad age-range, within which there are meaningful differences.

We have seen much coherence of separation and reunion behaviors in 2 1/2 - to 4 1/2-year-olds. If the child is very distressed, there is often some clear sign of insecurity on reunion. If the child continues active play, or shows constructive coping behavior (e.g., by asking to go get mother; by trying to engage the stranger) the child's reunion behavior is often secure. Yet, as in the strange situation, children showing identical behavior on separation can be given very different attachment classifications.

Development of the coding system

The data pool

In developing this system, we viewed approximately 300 videotaped reunion assessments of 2 1/2- to 4 1/2-year-olds with both mothers and fathers. These assessments came from studies conducted by Lela Beckwith, Jay Belsky, Inge Bretherton and Doreen Ridgeway, Dante Cicchetti and Marjorie Beeghly, Ann Easterbrooks, Robert Marvin, Marian Radke-Yarrow and Mark Cummings, Sue Spieker, and Joan Stevenson-Hinde. The procedures used in these studies fell into four groups: (a) a 20-minute separation with the stranger present but occupied followed immediately by a 3-minute alone period; then a 3-minute reunion with the stranger out of the room, in the midst of a longer laboratory assessment; (b) a 3-minute separation with the stranger present but occupied, followed immediately by a 3-minute alone period; then a 3-minute reunion with stranger out of the room, in the midst of a longer laboratory assessment; (c) the classic Ainsworth strange situation; and (d) a modified Ainsworth strange situation, consisting of two separations, two reunion, and no stranger.

The majority of the children we have observed have come from white, middle-class, two-parent families. The extent to which modifications of this system are necessary for use with children from other racial and socioeconomic groups remains to be seen. Ainsworth's infancy strange situation has been widely used with a variety of racial and socioeconomic groups. At the level of coding used with pre-verbal infants, no modifications have seemed necessary. This system for older children, however, relies heavily on the style, context, and patterning of speech, as well as on the child's understanding of social convention, all of which are likely to be influenced by such factors as race and socioeconomic status. Researchers must be careful not to assume that, for instance, behaviors considered here as markers of insecurity in white, middle-class children, American are necessarily markers of insecurity in other children.

Viewing procedures during system development

We have always considered the most important component in the development of the coding system as being the careful observation and description of the child's behavior. When viewing videotapes, we have used slow motion, freeze frames, fast-forward scan, and repeated observations to help us. Relevant behaviors can be difficult to see, and the coding process is a painstaking one. It was our practice to view videotapes independently, with no additional knowledge about the child, and to form independent judgements about the quality of that child's attachment. Subsequently, frequent discussion and comparison of notes among authors were useful.

Use of infancy data

Because of the striking stability of attachment from infancy to age six in the Berkeley sample (84% with mother, 60% with father; Main & Cassidy, 1988) and replicated in the Grossmann's German sample (85% with mother; Wartner & Grossmann, 1988), we were aware of the possibility that substantial stability existed from infancy to age 3 as well. The extent of this stability is, of course, an empirical question. But we were able to use the knowledge of infancy attachment classification as one of several pieces of information.

One additional technique that was used in honing observation was to check -- after the classification of a given child's 2 1/2- to 4 1/2-year reunion behavior had been reached -- the attachment pattern that had characterized the child in infancy (as assessed in a standard strange situation). Although there was never any intent to change decisions on the basis of the earlier assessment (no presupposition of individual stability in attachment patterns was introduced in developing the coding system) instances of marked early-by-later classification shift provided the motivation to re-examine the videotape in even more detail and force the coder to specify the behavioral basis of his/her judgement in even more precise detail.

We have, in general, kept the issue of stability separate from the issue of identifying preschool attachment patterns. In no case did we decide that the behavior of given child must be e.g., "secure behavior" because she had been secure in infancy. However, a strategy that can be useful is to examine a large group of three-year-olds who shared infancy attachment classification in search of commonalities. This permits the identification of commonalities to which one had not at first been sensitive. Later application of criteria developed in this manner to a separate sample of 3-year-olds provides information (1) about the usefulness of those criteria in other samples, and (2) about the degree of stability and change in the new sample. Learning the child's infancy attachment classification was always the last step in examining each reunion, so that this knowledge did not interfere with our initial perceptions of that particular child's behavior. Main (Main, in press; Main & Cassidy, 1988) has referred to such a procedure as an inductive "guess-and-uncover" method. A description of this component of Main & Cassidy's development of the 6th-year attachment coding system is given in Appendix III.

SECTION II. OBSERVATIONAL PROCEDURE

Certainly the choice of procedure is a critical element of research design, and a number of factors need to be considered. The reunions used in developing this system came from a variety of procedures, and the extent to which this system can validly be used with various procedures is an empirical question. It may well be that reunion behavior is sufficiently robust that this system has wide applicability -- but that remains to be seen. On the other hand, no coding system has infinite applicability. Many factors, particularly the degree of stress, the extent of unfamiliarity, and the level of activation of the exploratory system, will influence reunion behavior.

Two procedures are recommended here, followed by a number of general procedural considerations relevant to both procedures. Although a number of separation-reunion procedures have been used successfully in developing this classificatory system, the consensus has emerged that two are especially recommended for the study of attachment in this age-range. Both procedures contain two separations and two reunions. The procedure which we recommend in most cases is a version of Ainsworth's original strange situation used first by by Marvin & VanDevender (1978), in which the role of the "stranger" is eliminated. This modification is designed to make this procedure for preschoolers more stressful. The parent and child enter the room, and after 3 minutes, the parent leaves. The first separation is 3 minutes long, as is the first reunion. The second separation is 6 minutes long, and the second reunion is 5 minutes long. This procedure is outlined in Appendix IV.

A second procedure, which researchers may wish to use in particular circumstances, is Ainsworth's original strange situation, described in detail in Ainsworth et al. (1978). Instructions from that reference are attached here as Appendix V. This procedure may be useful when researchers are examining children at different ages (e.g., 1, 2, 3, and 4 years) and wish to use the same procedure across ages.

One is Ainsworth's original strange situation, described in detail in Ainsworth et al (1978). Instructions from that reference are attached here as Appendix IV. The other recommended procedure, used first by Marvin & VanDevender (1978), is a modified version of Ainsworth's strange situation in which the role of the "stranger" is eliminated. This procedure is described in Appendix V.

Researchers will benefit from talking with others who have used these procedures. We also suggest that researchers send pilot tapes to one of the authors; we may be able to offer procedural or videotaping suggestions that would strengthen the validity of the findings or that would facilitate the coder's task.

General Procedural Considerations

1. Instructions to the parent. We suggest that descriptions of the procedure and instructions to the parent not be given aloud in the presence of the child, who at this age can clearly understand them. Such a practice certainly changes the situation, so that the child may be apprehensive of separation long before it occurs. In general, we believe that instructions should be as simple and as open-ended as possible.

See Appendix VI for suggested instructions to the parent.

2. Focus of the study. Parents should be told that the researchers are interested in the child's (rather than the parent's) behavior. No special emphasis should be placed on reunion, so that it will be as natural as possible. Both of these points can be covered by telling the parent something like: "We are interested in children's responses to separations from parents. As far as what you do in the room -- do whatever you'd like. It doesn't matter." In addition, casual instructions for reunion, such as, "You can go in now," will also serve to keep the focus off of the reunion.

3. Leave-taking. Leave-taking is defined here as the period during which the parent is in the process of leaving the room. Whereas a parent can leave a pre-verbal 1-year-old with a mere "Bye-bye" or try to slip out unnoticed, it is likely to seem arbitrary or strange if the parent of a verbal preschool child tries to do so. Because how the child negotiates the issue of the parent's departure is relevant, it matters what kind of explanation she gives. The parent can be instructed what to say to the child on leaving, or it may be left entirely to her. One of us (RM) suggests that the mother be instructed to tell her child she has to make a phone call, that she has to go to the bathroom, or some similar, specific statement referring to her own behavioral goal. This procedure increases the likelihood that the child will attribute the decision for the separation to the mother rather than the experimenter, and may therefore be more naturalistic. One of us [JC] suggests that the experimenter leave it entirely up to the parent. The parent can be told ahead of time that she will be given a task while out of the room. The parent will then have a goal and context for leaving, and can use this task as an "excuse" if she chooses. Instructions related to leave-taking might be: "When you get the signal, we'd like you to leave the room however you'd like. The only thing we ask is that (child) stay in the room. We'll have a question form that we'd like you to look at while you're out here. " Researchers should consider carefully the different options, and make a decision thoughtfully.

4. Parent's activities during separations. The separation is defined here as the period during which the parent is out of the room. Different options again exist. JC recommends that the parent not enter the videotaping room. This can sensitize the parent to how very much under observation she and her child are, and may make her feel more self-conscious. The parent might remain near (but not immediately outside) the door so she can hear if the child becomes distressed. She might also be told that the videotaper will come get her if the child becomes distressed. The parent also might be given some sort of brief form to fill out while waiting, but she should not take it back into the room with her. RM, however, proposes that having the parent in the taping room demonstrates to her how the focus is on the child and not on her. And,

particularly with younger children, the parent may be more likely to be unsettled and fearful herself at not being able to see her child during separation. Certainly, the parent's presence in the observation room allows her to play a more informed role in deciding when/if to curtail the separation.

Whether the parent is in the observation room or in the hall, this time can serve as an opportunity for the experimenter to make more of a personal connection with the parent, to answer any of her questions, and to review the next step in the procedure.

5. Keeping the child in the playroom. Whereas 1-year-olds cannot reach a knob and open the door to search for mother if they wish, three-year-olds usually can. It would seem that it is a different experience for a 1-year-old to be unable to follow than it is for a 3-year-old. (It would be similar only if all the doors in the laboratory room had their knobs out of reach -- as is indeed the practice in some preschool nurseries.) What does one do to avoid an unduly frustrating situation, without equally unduly curtailing the separation? Ethical considerations prevent the experimenter from locking the laboratory door, or from holding the door shut from outside. A workable solution may be to have the examiner (or the "stranger," if one is used) waiting outside the door, and if the child opens the door, the experimenter could gently usher the child back into the room, reassure the child that the parent will return soon, and then leave again if possible. When the stranger remains in the room during child-parent separations, she might reassure the child that the parent will return shortly and remind the child to stay in the room, or attempt to reinterest the child in toys if he attempts to leave.

Some children will attempt to leave the playroom when the mother is in the room -- either at the moment of reunion, or later. The experimenter or stranger should stand outside close to the doorway (facing away), thereby physically blocking the exit. The stranger should not push the child or urge him to return. This should be left to the parent, to whom the instructions should be made clear. The way in which the parent and child negotiate this is of interest. The stranger should not say, "Go back in the room and play with mommy."

6. Curtailing the procedure. When a child is distressed, the procedure may need to be curtailed. The parent should be told at the beginning that she is free to curtail a separation at any time. The experimenter may also decide to curtail the separation, even if the parent does not seem concerned. Knowing when to do so involves an important decision which rests on a balance between alleviating distress that does not appear likely to end without the return of the parent, and allowing the child a brief time to recover on his own. This procedure is designed to examine how the child copes with a moderate amount of stress, and organizes himself in the face of it. Early curtailing of separation can make coding extremely difficult. It is helpful if the separation lasts at least long enough to determine whether or not the child appears able to comfort himself. The experimenter should try to have the separation be neither unnecessarily curtailed, nor unnecessarily prolonged. Separations with intense crying of greater than 30 seconds should be curtailed.

7. Reunion instructions. The reunion should not be "labelled" a reunion to the parent. No emphasis should be placed on it. The parent should simply be told, "You may go back in now." The parent should be asked to remain seated

in her chair.

Do not have the parent call the child's name, either outside the door before entering, or once inside the door. Although this instruction is often used with Ainsworth's infancy strange situation, this practice can create confusion for those coding older children -- particularly in relation to the assessment of avoidance. A secure child may approach, and upon discovering that the parent did not "want" anything, return immediately to play, creating a situation likely to be confused with the "greet and fall back" behavior characteristic of some avoidant children. Similarly, an avoidant child, because the parent has called him and he can approach the parent without risk of rejection, is more likely to approach than he might be otherwise.

8. Content of the playroom. Can a laboratory room be too large or too small? Can there be too few toys? Or too many? Can the toys be such that interest in them is too easily exhausted, or indeed is too absorbing? The answer to all of these questions is yes.

We have used a laboratory room of approximately 12 by 14 feet. Rooms that are much larger or smaller may present different situations. We suggest that there be an interesting assortment of toys, perhaps 12 to 15 toys, all or most of which can be used independently by the child, without requiring adult supervision. Toys that allow the possibility of dyadic play, such as a tea set or [illegible] ball, can be useful. A toy that permits physical activity, such as a rocking horse, can also be useful. We urge that books not be included, and that no table be centrally located in the room. (If a table has been used earlier in the procedure, it should be pushed against the wall.)

9. The "stranger." When a stranger is used, careful attention should be paid to selection of the stranger, to the instructions given to the stranger, and to the training of the stranger. A stranger who deviates from her instructions can make coding difficult or impossible.

The stranger's role is essentially the same as in Ainsworth's infancy strange situation. The stranger enters in episode 3 and sits quietly. For the last minute of that episode, the stranger engages the child in play. The stranger does not intercede during the parent's leavetaking. Soon after the parent has left the room in episode 4, the stranger returns to her chair, where she remains availble and responsive, but does not initiate play or interaction. If, during either separation, the child is distressed, the stranger should offer immediate and full comfort and reassurance, which may include physical contact. When leaving after the parent returns, the stranger should slip quietly out of the room. The stranger should be especially careful not to leave too quickly or leave in a fashion which distracts the child or parent from the reunion. The stranger should not say good-bye. Saying good-bye (or finishing the play activity) is a structured diversion at the important moment of the parent's return, and may make the coder's task more difficult.

The best strangers are those who understand children's signals and needs, who are sensitively responsive, who are comfortable and experienced with children, who can tolerate quiet times of little or no interaction (or even rejection), who are affectively appropriate to the situation, and who neither pull for attention or acceptance from the child, nor feel hesitant about offering comfort freely when needed. Strangers should undergo extensive training, and should watch the videotapes of the pilot subjects with which they train. It may be helpful if the stranger is sufficiently familiar with the coding system to understand the ways in which her behavior can make coding difficult. We suggest that new researchers send pilot tapes to an experienced coder who might be able to make suggestions about the stranger's behavior which would improve the "codability" of the tapes.

10. Videotaping. This procedural note is as important as any mentioned up to this point. The coding system uses information gathered from five modalities: physical proximity and contact, body positioning, speech, gaze, and affect. All of these modalities are enormously important to the coding process. Use of this coding system can be difficult and tedious. When loud air-conditioning vents or faulty microphone placement obscure conversation, or when poor lighting, poor camera placement, or inexperienced videotapers make it impossible to recognize affect, the coder can be seriously, perhaps critically, hindered, and the validity of data seriously jeopardized. We strongly suggest that careful attention be made to sound and visual quality, and to the training of videotapers. Close-up shots are essential. During the initial greeting, the camera should focus on a close-up of the child. (Shots should not be so close that important information, such as the fact that the child is looking at a toy and not staring at the floor or that he is kicking his legs stifly, is lost. Similarly, the camera should be in a position to move with the child in focus if the child moves suddenly.) For the remainder of the reunion, the camera should include both parent and child if they are sufficiently close together that the child's facial expressions are still quite clear. Otherwise, the focus should remain on the child, with brief occasional zoom-outs to include the parent. A well-executed split-screen set-up can also be useful. We suggest that new researchers send pilot tapes to an experienced coder who might be able to make suggestions about the videotaping which would improve the "codability" of the tapes. It may be useful to explain to the videotaper what is needed for successful coding, and to review examples of both poor and good videotaping.

11. Additional Procedural Notes.

a. If other family members have accompanied the parent and child to the laboratory, the child should be told (when feasible) that they have left the building. Otherwise, the child may be eager to leave the room to see them. It can be difficult to determine whether a child who, upon the parent's return, immediately opens the door and says, "I want to go see Daddy," is avoiding the mother, or simply eager to see the father.

b. The second reunion should be allowed to continue for 5 minutes.

c. A loud knock, particularly a knock on the door, as a signal to the parent can be problematic. When a knock is used as the signal to leave, the child may (naturally) believe that someone wants to enter the room, and may run to the door wanting to let him in. The child's reaction when the parent then refuses to let him open the door or go outside to "see who it is" may confuse the issue of the child's response to the parent's departure. Recent studies by Sue Spieker and by Cathy Booth have successfully used a parental "bug in the ear." A light tap on the window, away from the door, may also be effective.

Note: Although some diversity in details of physical setting, equipment, and procedure are perhaps unavoidable, undue diversity can only make reliable assessment more difficult to achieve.

SECTION III: THE SCORING SYSTEM

The scoring system contains two parts: classifications, which are described first, and rating scales. See Appendix VII for recommendations related to use of the scoring system.

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Classifications

At present, there are four attachment classificatory groups: secure, insecure/avoidant, insecure/ambivalent, and insecure/disorganized-controlling. Children considered insecurely attached can also be classified as insecure/other.

Table I outlines the four major classificatory groups and the subgroups that have been identified to date. (Because of large differences in the frequency with which the different classification groups are found in commonly-observed samples, the extent as well as certainty of criterial descriptions varies depending on what subgroup is at issue. Categories of "other" are provisionally included to accommodate patterns that do not conform well to the criterial descriptions.)

See next page for Table 1.

TABLE 1

ATTACHMENT CLASSIFICATION GROUPS AND SUBGROUPS

SECURE	INSECURE			
	AVOIDANT	AMBIVALENT	CONTROLLING-DISORGANIZED	OTHER
VERY SECURE	IGNORING	RESISTANT	CONTROLLING-CAREGIVING	-----
SECURE-RESERVED	NEUTRAL	IMMATURE	CONTROLLING-PUNITIVE	
SECURE-CONTROLLING			CONTROLLING-GENERAL	
SECURE-DEPENDENT			DISORGANIZED	
SECURE-FEISTY				
SECURE-OTHER				

Main's concept of attachment "strategies" (Main, 1981; Main & Weston 1982) is useful when considering the four attachment patterns identified in Table 1. The strategy refers to the means the individual uses in organizing behavior relevant to attachment.

A summary of attachment strategies associated with the secure, avoidant, and ambivalent patterns is provided in Appendix I. These strategies are thought to be present in infancy, childhood, and adulthood (see introduction; see also Main et al., 1985). The fourth major attachment classification group listed in Table 1 -- the controlling-disorganized group -- differs from the others in that the strategy of controlling the parent's behavior appears to have evolved from a lack of any consistent strategy for dealing with the attachment figure in infancy (see introduction; see also Main & Hesse, 1990).

In attempting to define the pattern of an individual's behavior toward the attachment figure, five modalities of behavior commonly provide the most relevant combination of sources of information:

1. Physical contact and/or seeking or maintenance of physical proximity
2. Body positioning
3. Content and style of parent-directed speech
4. Looking behavior directed to the parent
5. Verbal and non-verbal indices of affect.

The relevance of these individual modalities for coding varies across attachment patterns. With regard to both the secure and avoidant patterns, identifying features are precisely specified in all five modalities. This may be one reason why these are the two groups most easily identifiable. Conversely, with respect to the ambivalent and controlling-disorganized patterns, identifying features are specified in only some of the modalities. For instance, the speech modality is less specified in relation to the ambivalent pattern; more central are the modalities of proximity/contact and body positioning. On the other hand, it is the gaze modality that is least relevant to the identification of the controlling-disorganized pattern. The modalities of proximity/contact and body positioning are also less specified in this pattern. These children may seek proximity or contact, or they may move away; they may orient toward the parent or away from the parent. It is the child's behavior across the remaining modalities -- what he says and the nature of the accompanying affect -- that is most useful in decisions about placement in this group.

It is interesting to note that relevance of particular modalities shifts across development as well as across attachment groups. In infancy, the modalities of proximity/contact and body positioning are more important in making judgements of Ainsworth's three classic attachment patterns than are gaze and affect. (These latter modalities become more relevant when considering the disorganized/disoriented patterns in infancy, identified by Main [Main & Weston, 1981; Main & Solomon, 1986.]) Speech, in infants, is, of course, not relevant. By the age of three, behaviors in all five modalities become important, and although the modalities of proximity-seeking and body orientation remain important, others become equally important.

Descriptions of the classification groups follow.

Secure Group

Pre-separation

Securely attached children are generally interested in interacting with the parent during the pre-separation episode, but they vary in the extent to which they do so: some do so very little, some almost continuously, with most having at least some interaction. Children classified "secure-ambivalent" and "secure-controlling" are particularly focused on the parent and want her involved; they may not be interested in playing with the toys unless the parent participates. However much securely attached children want the parent involved, their bids for interaction are not clingy, pouty, whiney, demanding, or querulous, but pleasantly inviting.

Securely attached children use the parent as a secure base from which to explore. These children move to the toys with little or no delay. They may initially explore many objects briefly to get an overview of the possibilities, but soon settle to exploration of one or a few toys in greater depth. These children are interested in the properties of the objects themselves, and show careful, interested exploration. They are absorbed and reasonably constructive in their play. There is little flitting from one thing to the next. Younger children may spend relatively greater time manipulating objects, whereas older children may be more involved in thematic or pretend play.

We have seen no securely attached child show fear of the stranger. Some securely attached children may indeed still be wary of the stranger, but much less so than infants are. (If the child is wary, that by no means suggests insecurity.) Secure children (particularly children classified secure-ambivalent, or younger children) might go to the parent and lean against her legs. If they go to the parent, they look and smile at the stranger, rather than being fearful of her. Although securely attached children often do not approach the stranger immediately, most look readily and take an interest in her. They are usually quite cooperative with the stranger when she attempts to engage them. Ambivalence toward the stranger, which may come out in the form of coy behavior, is not uncommon with securely attached children (Marvin & Mosler, 1976).

Leave-taking

Some securely attached children accept the parent's leaving with little comment. However, others (particularly secure-ambivalent children, or younger children) are concerned about the parent's leaving. They may want to know why the parent is leaving, may want to go with the parent, or may want the parent to remain in the room. They may try to think of reasons why the parent should stay, or why they should be permitted to join the parent. In a minority of cases, negotiation is long and involved; more commonly it is brief and relatively smooth. Whether extended or brief, the leave-taking is generally not excessively long and drawn out, and perfectly miserable (as it is with some insecurely attached children). The process makes some progress, some forward movement, rather than wallowing or stagnating.

Although in general these children are more amenable to accepting a negotiation than other children, negotiation is not always successful. With some secure children, the parent leaves, the child is angry about it, and he remains angry until reunion.

Separation

Some secure children show no distress during separation, are very active, and continue with high-level play. Secure children who had been playing well with the stranger on separation, generally continue to play well with her during the separation. It is rare that a child classified secure at 3 or 4 who remains distressed on separation, as long as the stranger is in the room.

Some secure children (particularly those classified secure-ambivalent) show distress on separation, particularly if alone. This is usually manifested not by crying, but by muted exploration, waiting, and putting themselves "on hold." Securely attached children who are distressed are likely to actively go to the door and search for the parent, or to unhappily wait for the parent's return. Some distressed secure children grumble to themselves about their predicament. Younger securely attached children are more likely than older securely attached children to be distressed and to cry, but even then their crying is seldom "out of control."

Reunion

Children in this group are characterized by relaxed pleasure at the parent's return, and show little or no avoidance, ambivalence, or controlling behavior. The child appears to have a very special relationship with the parent, with interaction that is smooth, full, warm, and positive. There is a calm, comfortable interaction in which the child seems to enjoy and respect the parent. The general strategy guiding the behavior of these children seems to be the use of the parent as a secure base for exploring and interacting with this novel social and physical environment.

A range of behaviors may characterize the first few moments of reunion: the child may be relaxed and nonchalant, happy, or mildly sad or angry concerning the separation. Dyads vary in how they handle any negative feelings, with some engaging in open discussion and resolution of the feelings, and others "sidestepping" the feelings by focussing on some joint enjoyable activity or topic of conversation. In either case, the feelings are either verbally or non-verbally expressed and handled, and the child's affect quickly returns to relaxed enjoyment of ongoing activity.

Speech content. More than the children of other groups, the remarks of secure children are of a personal nature. Some of these children tend to discuss their feelings with the parent, and to keep the parent "updated" on their activities, thoughts, wishes, and feelings. They show an interest in the parent's thoughts and activities, and tend to seek information concerning her point of view. Other children, particularly those in the younger range of this age-group, relate most or all of the updating and exchange of perspectives to play activity. This interaction, however, is full, and does not entail the child simply asking the parent to repair a toy, or some other "business" interchange. Some children ask the parent to join in the play. If the conversation deals with a decision, the child is able to state his wish; if the parent disagrees, the child is able to accept the decision, or to negotiate in an open, non-whiney (or minimally so) way.

Speech style. The amount of conversational interaction between child and parent may vary greatly, but what does take place is smooth, initiated and responded to with pleasure, and "goes somewhere." Conversational interaction is characterized by fluidity, expansion, and comfort. These children may initiate conversation, and are at least readily responsive to the initiations of the parent. These children may expand upon the parent's conversation or give a fuller reply than necessary, indicating an interest in maintaining interaction. For instance, if the parent asks what the child has been doing, rather than simply responding, "Playing," the child might respond, "Playing with these trucks and planes. I like this blue truck. Want to see how it works?"

Main & Strage (1988) have described the discourse patterns of secure 6-year-olds and their parents as consisting of few ignored conversational turns, few long pauses or empty turns, and unrestricted topics. Both partners move the conversation forward. There is genuine dialogue, with few test questions, yes/no questions, or rhetorical questions. We have noted similar patterns with 2 1/2- to 4 1/2-year-olds.

Body positioning and movement. Although the child's use of physical proximity and contact remain important in 2 1/2- to 4 1/2-year-olds, organization differs from organization in infancy. In terms of frequency, physical contact is rarer in these children than it is in infants. In terms of style, the approach is more casual. The child may gravitate slowly to the parent, and physical contact, if it occurs, is understated (e.g., the child may rest her hand on the knee of a parent, rather than signal to be picked up). If the parent moves elsewhere in the room, the child may follow, although not necessarily immediately. If the parent initiates physical proximity or contact, the child accepts it comfortably, at least for a time. The child may also increase proximity to the parent by calling/inviting the parent to come closer ("See, this man slides down," when seeing would necessitate the parent's approach).

Even though physical contact may be less common at this age, children classified secure generally orient their bodies towards the parent. For instance, one 3-year-old was sitting with her side to the door; when her father entered, she casually turned, while talking, to face him directly. In sum, although the child's participation in casual, comfortable, non-hostile, and non-ambivalent physical proximity or contact with the parent suggests security, the lack of such behaviors does not preclude security. Proximity and contact are more common in children at the younger end of this age range than at the older.

Gaze. There is a range in the gaze patterns of children in this group. It is not at all uncommon, immediately on reunion, for a child to glance at the parent and then look away briefly. Soon, however, the child looks readily at the parent in ways appropriate to smooth interaction. There may be full, open, and direct gazes in some children. The child does not dart quick glances at the parent when the parent's attention is focussed elsewhere.

Affect. Affect is generally calm and friendly. The child is glad to see the parent, but shows this in a relatively calm way. Affect is in the mid-range. The child does not rush to the parent and seek to be picked up as secure infants often do; the child does not hop up and down gleefully shouting "Mommy, Mommy! Wow!" Nor is his affect "flat." Initial smiles are followed up with smiles or at least ready interaction throughout the reunion. Disagreements are negotiated with a minimum of negative affect. The child matches the affect level of the parent. Calmness and comfort pervade.

It is often useful to very carefully observe transitions from one affect-state to another. Securely attached children tend to make these transitions in a relatively gradual, smooth manner. Anxiously attached children more often make the transition relatively abruptly. For example, in carefully watching changes in facial expressions of anxiously attached children, the observer is often struck with the impression that the child "switches" a smile on or off in an abrupt, non-relaxed way suggesting self-control of that expression. In contrast, the smile of a secure child seems to "flow" to and from other expression in a more relaxed way.

Subgroups

At this point, we have identified five subgroups of securely attached 2 1/2- to 4 1/2-year olds: very secure, secure-reserved, secure-ambivalent, secure-fiesty, and secure-controlling.

very secure: What distinguishes the child in this subgroup is that she shows calm, comfortable enjoyment of the parent with virtually no avoidance, ambivalence, disorganization, or controlling behavior. (However, it is not uncommon for even the very secure child to glance briefly away from the parent at the moment of reunion, or for there to be a slight delay before full interaction.) Interaction with the parent begins almost immediately upon reunion. The child may greet the parent directly (with "Hi"), or may simply plunge into conversation ("I'm playing Lincoln Logs"; "Look, a giraffe!"; "I have to go potty"). Casual and comfortable physical contact may occur. The child may put her face very close to the parent's face in an intimate way, or there may be full, lingering eye-contact.

A child classified very secure can show much distress on separation. On reunion, however, he calms quickly, easily, and directly, and the interaction that follows is that described as characteristic of this category. The distress during separation should not be considered as necessitating classification as secure/ambivalent. For classification as secure/ambivalent, dependency must be shown when the parent returns.

Ainsworth (personal communication, 1987) has pointed out that the distinction that exists in infancy between very secure (B3) infants (who actively seek proximity and contact) and secure reserved (B1) infants (who pleasantly interact across a distance) does not exist for 2 1/2 to 4 1/2-year olds because even very secure 2 1/2- to 4 1/2-olds generally show pleasant interaction without particular interest in proximity or contact. However, a distinction between "very-secure" and "secure-reserved" 2 1/2- to 4 1/2-olds remains: secure-reserved children show more reserve in engaging the parent, but because proximity and contact are not the central issues that they are in infancy, this relative reserve is evident through observation of other behaviors, such as conversation, physical orientation, and gaze. In sum, although physical proximity and contact are defining features, required for classification as "very secure" in infants, they are not required for classification as "very secure" in these older children.

secure-reserved: Several patterns of reunion behavior are classified here:

(i) The child may appear "slow to warm up," with minimal responses at first and longer periods of not looking or orienting. Soon, however, the child warms up, and behaves toward the parent in a secure manner. Initial avoidance lasts 15-30 seconds. (If the child's slowness to warm-up has a "pouty" quality, see the secure-ambivalent subgroup.)

(ii): Children classified here show the same slowness to warm up as children classified in subgroup i, above. The distinction is that here, avoidance lasts somewhat longer, from 30-60 seconds. Following that, avoidance breaks down, and the child responds fully. Children placed in the avoidant group, on the other hand, either never warm-up to the parent, or display a mixed pattern of avoidance and initiation/maintenance or neutral, non-personal interation.

(iii): The child may be responsive to the parent from the beginning, but simply not look at or orient to the parent, or show as much interest in, or openness and ease toward, the parent as is characteristic of other secure children. The important distinction between children classified here and some avoidant-neutral children is that these children are clearly relaxed and responsive in a manner suggestive of security rather than neutrality.

Naturally, the secure-reserved subgroup can sometimes be difficult to differentiate from "neutral avoidance." The principal differentiating factor is that whereas the secure-reserved child does not display the full repertoire of very secure behaviors, (i.e., nearly immediate, calm, intimate, happy interaction with full gaze, and lengthy verbal and/or play interaction), he either displays all of these behaviors after a relatively short period of time (forms i and ii), or displays a subset of those behaviors (form iii). The avoidant- neutral child, on the other hand, tends to remain relatively neutral in tone, remain non-personal in the content of the interaction throughout, and refrain from lengthy, shared eye-contact, intimate physical contact, or invitations to join in play. Although the avoidant-neutral child may show some interest in interacting with the parent, the child seems to derive no pleasure from the interaction, and it does not seem comfortable.

(See the following section on the avoidant classification for further discussion of this distinction.)

[Note: In the interest of further refinement of the "secure-reserved" subgroup, note the form (i-iii) of each child thus classified.]

secure-ambivalent: This subgroup, which exists both in infancy (B4) and at age six, also exists at this intermediate age. The behavior of children in this group is generally secure, but elements of immature, dependent, ambivalent, or resistant behavior are also present. (See the later section describing the insecure/ambivalent pattern for descriptions of these elements.)

In the context of security, some children who should be classified here direct initially pouty behavior toward the parent, which may cause them to be "slow to warm-up." Others are quiet, focussed on the parent, and seem a bit "fragile." This poutiness or fragility is a direct expression of hurt and/or displeasure, and should not be confused with the reserve of slow to warm-up children classified secure-reserved: the latter children appear neutral initially, and then behave in a more secure manner.

Distress on separation, within the context of security, does not necessitate clasification here. See the description of very secure children.

secure-feisty: These children show a confident bossiness, a self-assertion in relation to the parent. They may show playful scorn or mocking of the parent, or pretend exasperation. One child given this classification repeatedly put her hand on her hip and sighed with playful exasperation while looking directly at her mother. These children may be considered "full of themselves," "cocky," "sassy," or "high-spirited." This attitude may be, but is not necessarily, affectionate in nature. This self-assurance may result when a parent is intrusive or controlling, and when the child stands up for herself or defends her own choices. This subgroup is also present in Main & Cassidy's sixth-year system.

Be careful not to classify children as secure-reserved who should be classified here. Some secure fiesty children do not speak at first -- they either don't answer or they direct their attention elsewhere. In this case, the silence reflects more suborness than avoidance. If the rest of the reunion reflects fiestiness, code here rather than as secure-reserved. Secure-fiesty children emphasize the relationship and have a confidence in it that secure-reserved children often do not.

The distinction between secure-feisty and secure-controlling can also be difficult. The focus of children classified secure-fiesty seems to be on showing off the self, whereas that of children classified secure-controlling seems to be on controlling the parent.

Children classified secure-fiesty are considered to be conceptually linked with children with children classified secure-ambivalent. Children in both subgroups can be viewed as showing a somewhat exaggerated emphasis on the relationship. In Main & Cassidy's (1988) Berkeley longitudinal report, most children who had been classified B4 in the strange situation as infants were either secure-fiesty or secure-ambivalent at age 6. For these reasons, these two subgroups are combined when determining inter-rater reliability.

secure-controlling: Children are also placed in this subgroup when their behavior is generally considered secure, but there are traces of controlling behavior as outlined later in these guidelines. Thus, if in the context of generally secure behavior, the child shows isolated instances of trying to control the parent, the child is given this subclassification. This controlling behavior can take one of three forms: either caregiving control, punitive control, or a general control with both caregiving nd punitive elements. (Note re: Secure/controlling-caregiving: It is important not to view every instance of the child's doing something for the parent as potential caregiving. The very secure child can be helpful toward the parent. Children are coded as secure/controlling-caregiving who fall in between the very secure child, who occasionally helps the parent, and the child classified "insecure/controlling-caregiving," who has taken pervasive control of the interaction in ways which appear motivated by a desire to helpfully guide the parent, orient her, or cheer her up.)

secure-other: This subgroup is used for a child who seems basically secure, but for some reason does not fall into any of the other subgroups, or who seems to be a clear mixture of two or more of the secure subgroups. It seems a better strategy to use this subgroup than to force a child into a subgroup into which he does not readily fit. One child placed in this subgroup showed generally secure behavior, but had moments of being rather shrill and made a few tense faces. Another child placed in this subgroup behaved in a vague, disinterested, unfocussed but responsive manner for the first minute. After that, he behaved in a classic very secure manner -- he engaged his father in play, he leaned casually and comfortably against his father, he put his face close to his father's face to show him his sunglasses, he engaged in full, initiating, warm, and personal conversation. This subgroup will serve as a less-defined, heterogeneous group until enough cases are accumulated to allow placement into different well-defined groups. This subgroup also appears in Main & Cassidy's sixth-year system.

Insecure/Avoidant Group

The instructions given for coding avoidance in Main and Cassidy's (1987) manual for use with 6-year-olds are also useful for 2 1/2- to 4 1/2-year-olds. These instructions include three sections: (a) Indications of avoidance; (b) Forms of greetings, speech, and proximity-seeking consonant with high avoidance; and (c) Forms of greetings, speech, and proximity-seeking inconsonant with high avoidance. For a better understanding of avoidance, we strongly suggest that coders read these instructions, which are provided here as Appendix IX.

Pre-separation

Avoidant children are likely to explore during pre-separation with little or no involvement with the parent. If there is involvement, it tends to be conversation focussed on the toys or on some other "neutral," non-personal topic. (Note: Many secure children talk only about neutral topics, so this cannot be a sufficient criterion for classification.) Parent and child often appear either to be "unconnected," or to act as "friendly acquaintances" rather than as parent and child: they seem to be on parallel tracks. Most avoidant children show little or no wariness of the stranger. Older avoidant children are often much more subtle in their avoidant and neutral behavior than younger avoidant children.

Leave-taking

Many avoidant children (particularly older preschoolers) appear not even to attend to the parent's leave-taking, although others (particularly the younger ones) will approach and question the parent, or object to the separation. Among those who approach the parent on leave-taking, many avoid actually making physical contact, or do so only briefly. For example, one child classified avoidant reached out to touch her mother while asking where she was going, but stopped and withdrew her hand just before she touched her mother's arm. Avoidant children are less likely to cry than children in any other group.

Separation

Avoidant children are highly unlikely to be overtly distressed during separation. Play during separation can take a range of forms: some children play well, while others are active, but not terribly imaginative or constructive. Play can be simple, repetitive, and short. Some children will stop play and simply wait for the parent's return.

Reunion

The general strategy guiding the behavior of children classified avoidant appears to be the maintenance of neutrality. Sincerely intimate, personal behavior -- either positive and affectionate or negative, angry, or hostile behavior -- is rarely expressed toward the parent. In general, the child behaves as if the parent's return has little of the special meaning usually associated with a parent-child relationship. The child treats the parent as she might treat a teacher or next-door neighbor with whom she shares no special connection but with whom she is willing to be civil.....and in some cases, even pleasant.

The child's goal does not appear to be to avoid interaction altogether, but rather to avoid interaction which might call attention to the relationship. Therefore, this child will tend neither to share a joyful or relaxed "intimate moment" at reunion, nor to call attention to the relationship by being punitive or stubborn or by refusing to answer when social convention clearly calls for a response. In other words, this child does not want to "rock the boat" in either a positive or negative direction. This group is similar to the avoidant group of six-year-olds described by Main & Cassidy (1988).

Neutrality in interaction is expressed through several modalities.

Speech content. These children rarely make personal comments about their feelings or state. Topics tend not to relate to things in which the child is personally invested. Instead, comments are limited to the toys, the room, ongoing events.

[Note: Although personal conversation generally precludes classification as avoidant, education- or play-focused conversations do not preclude classification as secure, particularly with children at the young end of this age range. The context should be considered, as should whether or not the toy-focused speech distracts from potential personal interaction. Avoidant children focus on objects in the service of keeping the parent available but "at a distance," whereas secure children use objects as a means of bringing the parent into their world.]

Speech style. The style is consistent with a goal of neutral avoidance of interaction (in the more extreme cases), or at least of maintaining a careful neutrality in interaction. Thus, many of these children do not initiate conversation during reunion. Those who do rarely discuss personal topics.

When asked a direct question, these children do one of two things. (a) They may attempt to avoid interaction in a neutral manner, if possible. Thus, if the child is facing away from the parent and engrossed in a toy, the child might "not hear" the parent, might drop a toy, or might suddenly see a toy of great interest across the room. All of these behaviors would preclude the necessity of a response and would result in a shift of attention away from the parent-child dyad. (b) They may respond minimally, simply enough to fulfill the requirement of answering ("Yes;" "A bottle;" "Playing;" or even a gesture as in nodding the head to signal "yes"), or impersonally. Some children maintain a "running narration" of their play. It is important to note that this is not necessarily a conversation, whether or not it appears to be a response to a comment by the parent. This narration may also have occurred while the child was alone. In fact, such narration may serve actually to preclude true conversation.

Main & S'rage (1988) have described the discourse pattern of avoidant children and their parents as consisting of long pauses, empty turns, ignored overtures, rhetorical questions, and yes/no questions. The parent controls the verbal interaction. Topics are limited and impersonal. The parent may speak with the experimenter more than with the child. We have noted similar patterns in 2 1/2- to 4 1/2-olds.

Body positioning and movement. At the moment of reunion, the child may move away from the parent, often in the process of moving toward a toy. One child oriented to the door as it opened, but took a step backwards. The child who is facing away from the door at the moment of reunion may either turn with just a look or a brief greeting, or may not turn at all. If, on reunion, the parent moves directly in front of and facing the child, the child may remain oriented to the parent and maintain neutrality in other ways. Or the child may also move away later during the reunion. The child may play with her back to the parent for extended periods, or may keep the body angled away from the parent.

There is little initiation of physical proximity or contact by the child. However, the child may approach the parent for a "business" reason, e.g., to fix a toy. The child may also initiate hostile or aggressive physical contact (e.g., jabbing the parent briefly with a toy mouse). This has an impersonal tone to it, is within the context of play, and does not violate the overall neutral quality of the interaction. In addition, the hild may move to the parent if the child is concerned about the parent leaving the room. If the parent initiates proximity or contact, the child does not accept it comfortably, and may soon move away.

Preschool children are similar to infants (and not to six-year-olds) in that instances of dramatically moving far away from the parent or of keeping the full back towards the parent for long periods of time are common as strategies of avoidance. (Perhaps six-year-olds have developed more sophisticated defensive strategies that permit ignoring even in close physical proximity.) However, it is important to remember that even at ages three and four, children can remain near the parent but limit their affective exchanges and interaction to such a degree as to be categorized avoidant. Preschool children are different from infants (and more like six-year-olds) in that they do not consistently ignore and refuse to respond to a parent who speaks directly to them.

Gaze. In extreme cases, avoidant children may completely avoid eye contact with the parent. In less extreme cases, there may be eye contact, but it tends to be "business-focussed," and does not have the full, open, direct, or lingering quality typical of secure children. The child may look to the parent briefly, but then quickly look elsewhere, especially if the parent looks directly at the child. Certainly among avoidant children there is an absence if relaxed, intimate, mutual gaze.

Affect. The child's affect is largely neutral. It appears unlikely that the child could/would break this neutrality more than momentarily with either strong positive or negative affect. This neutrality is distinct from an overt expression of depression. The initial greeting may be casual and dismissing. On the other hand, there may be an initial smile at the moment of reunion, which may be relatively broad, but this smile is not followed up during the course of the reunion with other indications of a special relationship. If the parent presses the child for interaction, the child may respond with nervous giggles or movements, as if uncomfortable with the attention. The child may appear rushed, and so busy with the toys that there is "no time" for the parent. The degree of neutrality can vary from extreme, where the child displays no smiles and little or no change in facial expression, to mixed, where the child displays some affect within an overall tone of neutrality. In the latter case, there can be smiles and/or a happy or enthusiastic tone of voice, but this positive affect returns abruptly to neutral once the exchange is over. Conversely, the affect of secure children undergoes a more gradual change from one state to another.

Subgroups

Children can be classified, as in Main & Cassidy's sixth-year system, as either avoidant-ignoring, or avoidant-neutral. As in Ainsworth's system for one-year-olds and Main and Cassidy's sysum, the difference between these two subgroups relate to degree of avoidance/neutrality, and to patterns of interaction. Context is particularly important in deciding subgroup placement. If the parent's immediate behavior reduces the child's expectation of rejection, the child may display less avoidant behavior while still maintaining neutrality.

avoidant-ignoring: While maintaining neutrality, the child ignores the parent as much as possible for all or most of the reunion. The child may show both strong physical and strong conversational avoidance. The child looks at the parent only minimally, and may never turn to look at her. These children tend not to initiate conversation with the parent, and respond only minimally. As with both one- and six-year-olds, children placed in this subgroup tend not to warm up to the parent over the entire reunion, and receive very high scores on the avoidance scale. A child who, following 2 1/2 minutes of being turned away from the parent and responding minimally, offers a fuller response and/or an initiation, may nonetheless be classified here.

[Note: A child who is highly ignoring or avoidant of the parent in reunion 1, but who in reunion 2 responds to the parent's initiations and even initiates interaction (though not of a personal or warm nature) may nonetheless be classified as avoidant- ignoring rather than avoidant-neutral. This coding decision is based on the theoretical notion proposed by Bowlby, by Ainsworth, and by Main that avoidance is a defensive process used by the rejected child when she fears her attachment behaviors will be rejected. If the immediate context of a particular situation somehow reassures the rejected child that her attachment behavior will not be rejected, she may not use as highly avoidant a strategy as she might otherwise use. The avoidant child does not seek contact in times of heightened stress, but only when stress is low. Sroufe (1983) reported this pattern in the preschool setting where avoidant children did not approach the teacher in times of trouble, but would sit on her lap "with thumb-in-mouth" during story-time. Similarly, in this procedure, if the parent initiates and makes it quite clear that she will accept interaction on reunion (thereby creating a low-stress situation), the child may feel free to respond, and even to expand or initiate. This is particularly true following a period (e.g., reunion #1) in which the child has been highly avoidant of the parent -- thus having established a pattern in which her attachment behavioral system is not activated, and she is not rejected.]

avoidant-neutral: Children placed in this subgroup receive moderate scores on the avoidance scale. Interaction is neutral, not personal. These children display a moderate degree of avoidance combined with some interaction -- in some cases even initiation of interaction -- with the parent during at least some of the reunion. The interaction deals with something neutral and "business-like," and has the flavor of being civil and "friendly" rather than intimate.

Unlike the avoidant-ignoring child, and somewhat akin to one-year-old children classified A2, some of these chidren display mixed affect: clearly neutral affect combined or alternated with some brief and mild positive or negative affect. It is as though some of the child's anger or delight momentarily "breaks through" his attempt to remain neutral, following which he again regains control. At times this mixture takes on a mildly tense or forced appearance. The child's affect and/or interaction is not as relaxed as that of a secure child, nor as flat and neutral as the avoidant-ignoring child.

This child may greet the parent upon reunion, may initiate conversation during the reunion, and/or may expand on the parent's conversation. If so, however, the child will also display clearly avoidant behavior, such as rarely or never glancing at the parent during the conversation, or maintaining a degree of neutral facial expression which seems inconsistent with the conversation.

Older preschoolers can be more subtle in this pattern than younger preschoolers, and the observer must watch for mild, coinciding cues indicative of initiating or maintaining neutral interaction. For instance, a 30-month-old avoidant-neutral child might greet mother immediately upon reunion, orient away from mother, and play by himself for some time, then suddenly approach mother and discuss the operation of a toy with her. While standing near the mother, the child may maintain a foot or two of distance. He may immediately follow this interaction with a return to quiet play oriented away from the mother. On the other hand, a 48-month-old child might follow a greeting with a "barrage" of statements about toys, activities, etc. The child may glance at the mother, yet avert his gaze each time the mother looks at him. While this child is interacting with the mother, it is clear he is not relaxed. In fact, his tactic appears to be to keep involved and interacting with the mother while at the same time clearly maintaining a distance or lack of intimacy.

This neutral avoidance combined with initiation or maintenance of interaction is sometimes difficult to distinguish from patterns characteristic of other (sub)groups. It is distinct from avoidant-ignoring in that this child is less avoidant and is active in initiating or maintaining interaction. It is distinct from a secure-reserved pattern in never achieving the degree of intimate interaction typical of many secure-reserved children, and/or in having a mildly tense, non-relaxed tone throughout the reunion which is not typical of secure-reserved children. It is distinct from the ambivalent group in that here there is an attempt to shift attention away from the relationship, whereas ambivalent children often shift attention toward the relationship.

Continuum of avoidance in avoidant and secure classification groups (see avoidance rating scale [Appendix IX] for details):

avoidant-ignoring: extreme avoidance, both physical and conversational, which persists throughout , or nearly throughout, the entire reunion.

avoidant-neutral: less extreme avoidance; avoidance mined with initiation and/or maintenance of conversation, with the conversation remaining neutral and non-personal.

secure-reserved: "slow to warm up" but fully responsive within the first minute; or responsive throughout, but not as fully as children classified "very secure"; slight mutings.

very secure: no avoidance beyond the first 20 seconds; full, easy interaction throughout; personal and intimate.

Because avoidance is on a continuum, choosing a classification between the border of insecure/avoidant-neutral and secure-reserved can be difficult. A summary of the range of behaviors available for children classified avoidant is given below, listed by behavioral domain:

physical:

1. stays oriented toward the parent
2. moves closer, but only for a "business" reason, or if afraid the parent will leave
3. turns/moves/stays away

conversation:

1. no greeting, but shows toy right away
2. limits conversation
3. talks continuously, narrating play
4. ignores conversation while focused on toy
5. shows toy; initiates comments about play
6. no personal comments
7. no invitation to play
8. no fluid conversational turn-taking

gaze: few looks; no full looks; brief glances.

affect:

1. neutral; no sense that neutrality could break down and be replaced with either true positive or negative engagement; A2's show mixed affect, but neutrality prevails.
2. most positive affect has tense elements
3. busy with toys to the exclusion of P, except for running play narration

Insecure/ambivalent Group

Pre-separation

More than that of other children, the pre-separation behavior of insecure/ambivalent children is informative for purposes of classification. These children are more likely than others to clamor for attention, to want to be held, and to show other dependent behavior. They may hang onto the parent, and may be fussy, conflictual, whiney, and clingy. They may be reluctant to explore away from the parent. the extent of preoccupation with the parent may be inappropriate given that there is presumably little or no stress during the pre-separation episodes.

These children may be ambivalent in relation to the parent. They may seek contact, and when it is forthcoming, they may then not want it, or may find it somehow unsatisfactory. They may attempt to pull the parent into interaction, and then be unhappy once the goal is accomplished. An undercurrent of anger tends to run through the interaction, particularly with children classified ambivalent-resistant.

In relation to play, insecure/ambivalent children are likely to claim to be helpless, saying, "I can't do it," or "It won't work." This self-presentation of helplessness pulls the parent into interaction with the child, which the child may then fight against. Play is often fragmented, with the child flitting from one thing to the next, getting little accomplished, and playing with no great interest in a toy's specific properties and possibilities.

Insecure/ambivalent children are more likely than other children to be either frightened or uncooperative with stranger, and to seek the parent on the stranger's entrance.

Although the dependent, resistant, or ambivalent behavior patterns described here are usually found only in children classified insecure/ambivalent, they can be found in children in other groups as well. In addition, not all children in this group show these behaviors. The pre-separation child-parent interaction of some children in this group can be quite warm and smooth.

Leave-taking

Leave-taking is often conflictual and unresolved. There is much wallowing and little progress. The child may be fussy or whiney. The distress may have a phony, manipulative sense to it. Discourse is often convoluted, conflictual, unproductive, cloying. There seems to be no reasonable hope that child and parent will find a comfortable negotiated settlement. No matter what the parent says, the child finds something wrong with it. These children tend to seek contact, and may be picked up. Children may be ambivalent about contact, and not truly comforted by it. Some children do not protest separation, but look very sad and anxious, and may cry once the parent has left.

Separation

This is the only group at this age likely to be highly distressed during separation. Some children, particularly younger children, will show pure distress, even a tantrum; others, particularly older children, seem to be working at it -- there is a forced quality to the distress. There may be passive behavior, including huddling, or lying prone. There may be a very fast escalation of distress, with immediate screaming. This may come after the parent has left, when there is no possibility for negotiation.

Reactions to the stranger vary. Some of these children, especially younger ones, reject the stranger. Many of the older children show smooth, easy, and happy interaction with the stranger "sandwiched" between leave-taking and reunions with the parent which are fraught with struggle, unhappiness, and ambivalence.

Reunion

The reunion behavior of these children is congruent with an underlying attachment organization in which the child's dependence on the parent is emphasized. Children may emphasize their dependence by such behaviors as climbing on or clinging to the parent, following the parent around the room, trying to be held by the parent (particularly at times other than reunion), trying to prevent the parent's departure, or whining. Children may appear preoccupied with the relationship with the parent, to the hinderance or exclusion of exploration. This emphasis on dependence may be an attempt to gain the parent's attention.

The display of behavior emphasizing the child's immaturity and dependence on the parent may also take other forms : sucking fingers, showing the abdomen, wriggling the body, cocking the head, using "baby talk," tugging on clothes, and whispering. These behaviors are often seen as coy and attractive to strangers (Marvin & Mossler, 1976), but in any interaction are indicative of uncertainty (or at least the semblance of uncertainty) and at least some ambivalence and self-consciousness. Big "toothy" grins, as part of a coy expression, may also be present. The age of the child should be considered when making judgements about what is considered immature behavior. Obviously, certain behaviors appropriate to a child at the young end of this age range might be considered immature in a child two years older.

Accompanying this seeming immaturity, there may be a significant element of ambivalence. This ambivalence can take the form of mild anger, resistance, or avoidance. There can be ambivalence about physical proximity or contact. This takes the form of talking to the parent while the back is turned to the parent, standing near or in contact with the parent while silently and unhappily facing away, approaching the parent from the back and leaning against the parent so that the child's front is on the parent's back, lolling about or rolling on or near the parent. Ambivalence may also be evident in the child's attempts to derive comfort from the parent: he may seek comfort from the parent, but be unable to actually derive such comfort. Essentially, he is unable to use the parent as a secure base. However, children may be classified here even when there is no ambivalence.

There can be mild to moderate avoidance early in the reunion. Note, however, that high or extrememly prolonged avoidance (greater than 2 minutes) is not congruent with classification here. If such high or prolonged avoidance is followed by later behavioral characteristics of children in the ambivalent group, the child is considered to combine behaviors from two different groups, and is classified Insecure-Other.

There can be a scattered and fragmented sense to the reunion as a whole. The child flits from one activity to another and wanders back and forth to the parent, and no mutually satisfying interaction is carried on.

There can be angry displays of direct resistance, petulance, annoyance, frustration, contrary willfulness, and even temper tantrums. Although behavior of this sort certainly can be viewed as controlling, as can attempts to prevent the parent's leaving, and attempts to be held by the parent, they can also be viewed as immature and dependent. At this point, these are coded as probable indications of dependency rather than of controlling behavior.

The controlling nature of these behaviors may make them difficult to distinguish from behaviors considered indicative of "punitive controllingness" (see next group). In general, behavior coded here is a direct willfulness related to the child (e.g., I want more toys!!) rather than an attempt to control the parent (e.g., Don't touch my toys, mommy!!). Children classified in this group often behave as if they do not believe their wishes will be met unless they fuss and whine: assuming that control within the relationship lies with the parent. These children can be viewed as "entangled" with the parent, not as trying to control her. Children classified controlling-punitive, on the other hand, (see next group) make their commands with the assurance that they will be heeded, with a superior rather than a plaintive tone, with little fussing or crying: assuming that control within the relationship lies with the child.

In spite of these petulant, dependent, or ambivalent behaviors, portions of the child's behavior when interacting with the parent can be quite warm and intimate. Although the child might be classified secure if these portions alone were viewed, such behaviors do not preclude classification in the insecure/ambivalent category. However, Main (personal communication, 1989) has suggested that some insecure-ambivalent children (particularly at the upper end of the age range examined here) behave in a "pseudo-secure" manner, appearing to exert considerable effort to demonstrate how close the dyad is (see Main & Cassidy, 1987, for further details).

Subgroups

Two subgroups have been identified.

ambivalent-resistant: These children may show direct, angry, whiney resistance, which can vary from mild to extreme. The whineyness and the hierarchical structure which that suggets can be viewed as indicative of dependency. If these children are distressed by separation, it may take them a long time to calm down and return to play. Children classified here may struggle with their parents. This often takes the form of the child wanting to engage in some activity while the parent discourages him through reasoning, encouraging, distracting, cajolling and/or firm assertion of parental authority. This dyad is distinguished by its tendency to continue this struggle for much of the reunion episode, suggesting that the struggle has more to do with the relationship than with the "surface" content of the struggle. These children show their anger directly to the parent, but without the principal aim of trying to control the parent. Anger to the parent may be mediated through play, with children being resistant to the parent's involvement in or suggestions related to toys and/or play. The child's hitting of the parent is a strong indicator for placement in this group.

Ambivalence to physical proximity and/or contact may be a strong component. The child may also show a good bit of giggling and laughing in combination with resistant behavior. The child may actually "hang" on the parent, or may show "loving" behaviours such as hugging, sitting on the parent's lap, etc. However, these behaviors will be mixed with signs of ambivalence, such as intention movements away, slapping at the parent, and arguing.

ambivalent-immature: These children may emphasize their dependency on the parent through immature and coy behaviors, or through passivity. Ambivalence to physical proximity and/or contact may be a strong component. Helplessness, passivity, and despair may be present. Huddling on the floor may occur on leave-taking. The child, if he has been distressed during separation, may continue crying and/or remain in a distressed position, and passively await the parent's approach, rather than taking the initiation for proximity or contact. If the parent picks up the child, the child may be petulant and difficult to sooth.

This child may remain generally quiet through much of the reunion, conversing through whispering and "baby talk." The child may follow the parent around. In this case, the reunion may have a very soft, fragile, feel to it, with the child engaging in no real exploraiton.

It is sometimes difficult to distinguish the insecure/ambivalent-immature child from the secure-ambivalent child. The distinction rests primarily on use of the parent as a secure base from which to explore. The secure-ambivalent child may maintain a degree of quiet "fragility" but still enjoy playing with the toys and/or conversing with the parent. The insecure/ambivalent-immautre child will tend not to engage in enjoyable play and/or interation.

Behaviors of children in both ambivalent subgroups can be viewed as attempts to gain the parent's attention. That these children might engage in such attention-seeking behavior is congruent with research suggesting that mothers of ambivalent infants are the most inconsistent in their availability (Ainsworth et al., 1978), and the most underinvolved with the infant (Belsky et al., 1984; Isabella, Belsky, & von Eye, 1989; Smith & Pederson, 1988) during the infant's first year. The whiney and resistant behavior of children in the ambivalent-resistant subgroup can easily be viewed as an attempt to gain attention. Main & Solomon (1986) have stated: "In its heightened display of emotionality and dependence...this [group C] infant successfully draws the attention of the parent." The immature behaviors of children in the ambivalent-immature subgroup can be viewed in the same light: these children may believe that their wishes will not be met unless they display particular behaviors. If the proposition that wriggling and whispering "are often seen as coy and attractive to strangers" is valid, then perhaps -- in the child's mind -- the parent will see such behaviors as attractive as well and will attend to them (Lisa Berlin, personal communication, November, 1988).

Insecure/Controlling-Disorganized Group

At this point, this group consists of children who are, on reunion, either controlling, disorganized, or both.

It may not be clear to the reader why we have chosen, at this point, to include insecure/controlling children and insecure/disorganized children in one group. This decision stems from an awareness that in two longitudinal samples (Main & Cassidy, 1988; Wartner & Grossmann, 1988) the great majority of infants who had been classified insecure/disorganized-disoriented in infancy were classified as insecure/controlling at age six. Main & Cassidy have proposed that this shift represents a shift at the behavioral level due to developmental changes within the child, but that the underlying attachment organization remains the same. Main & Hesse (1990) have proposed possible reasons for this shift (see introduction of this manual). If the assumption that this shift occurs is in fact valid, it is possible that children in this intermediate age may range show combinations of both disorganized and controlling behaviors. On a conceptual level, disorganization in present in both subgroups: in one, the child's behavior is disorganized; in the other, it is the usual hierarchical structuring, with parent in control of child, that has become disorganized -- or at least seriously disordered. For the present, we have accepted the notion that these two seemingly different behavioral responses on reunion are manifestations of the same underlying attachment organization, and given this, we feel that including both disorganized and controlling children in one group reflects the most accurate categorization. We recognize that additional data and refinements to the coding system may make it apparent, at a later point, that placement of these children in separate groups is more appropriate.

Pre-separation, separation, and leave-taking

The range of pre-separation, separation, and leave-taking behaviors shown by children in this group encompasses that characteristically shown by children in the other three attachment groups. There is little that is particularly unique or characteristics about the behavior of these children during these episodes. Controlling children can be friendly and compliant with the stranger, but controlling when the parent enters. They also may appear to be more organized and explore more when alone or with stranger than when with the parent.

Reunion

Children classified controlling have taken control of the interaction and of the relationship during reunion. The strategy of these children may be to reduce uncertainty/unpredictability through taking charge themselves. When the parent cannot be counted upon, when the parent is too unpredictable, the child may choose to provide some structure through controlling the parent, rather than increasing demands on the parent's attention as the insecure/ambivalent child does.

Subgroups

There are three sub-groups of controlling children: controlling-caregiving, controlling-punitive, and controlling-general. Children in these subgroups may also show elements of disorganization.

controlling-caregiving: The child's control of the interaction seems to be motivated by a desire to helpfully guide the parent, orient her, or cheer her up. There may be a sudden shift in the child's movements at the initial moment of reunion, a rush toward the parent, a jumping up and down, a clapping of hands -- some great show of "happiness" on the parent's return. (This is in contrast with secure children, who, although they are pleased at the parent's return and express this, remain relatively calm.) The child may give the parent an overly cheery or "bright" greeting. It may be the case that this "bright" greeting is not followed up with positive affect and intimate interaction during the remainder of the reunion. Or the child may remain calm during the initial moments of greeting, and become excessively cheery during the course of the reunion. The child may direct the parent's activities, the flow of conversation, and may give an excessive structure to the interaction. Bretherton (personal communication,1987) has pointed out that it is important not to view every instance of the child's doing something for the parent as potential caregiving. The securely attached child may very well be helpful and cooperative.

controlling-punitive: The child has taken control of the interaction in a punitive or hostile manner. The child controls the parent, perhaps by telling her what to do in a derogatory, annoyed, or angry manner. Or, the child controls the flow of interaction, and is punitive by repeatedly refusing to speak when spoken to when it is quite clear that the child has heard the parent and the parent desires or expects a reply. Note: Just as every instance of the child's doing something for the parent should not be viewed as potential caregiving, so every instance of the child's attempts to control adult behavior should not be viewed as controlling-punitive. Beeghly (Beeghly & Cicchetti, 1987; Beeghly, Terry, & Cicchetti, in press) has found that speech acts functioning to control adult behavior increase dramatically during the third and fourth years of life. This is a general age-related effect which should be considered when coding "controllingness." Context is again important. If, for instance, the parent is being intrusive and the child simply stands up for herself, this behavior is not considered controlling.

Several distinctions related to punitive controllingness are sometimes difficult to make:

There is a (sometimes difficult to make) distinction between direct hostility and controllingness. Not all hostility is controlling. Direct hostility is generally characteristic of children classified insecure-ambivalent/resistant.

There is be a (sometimes difficult to make) distinction between the child's controlling the parent's actions, and the child's emphasizing dependency through strongly protesting separation, trying to get the parent not to leave the room, trying to accompany the parent, etc. Certainly these later behaviors can be viewed as controlling the parent's behavior.

At this point in the development of the system, these children are classified as insecure-ambivalent/resistant. See the previous section for a fuller discussion of this point.

There is a (sometimes difficult to make) distinction between the child's not replying to the parent in an avoidant manner, and not replying in a punitive manner controlling of the interaction. Certainly, not replying in any form can be viewed as a means of structuring (i.e., controlling) the interaction. But as long as the interaction maintains the appearance of neutrality, then it can be considered avoidant. Avoidant children appear not to have heard the parent, or counter with a response that maintains neutrality (prevents personal conversation). The punitive child is not concerned with neutrality, and will not answer even when it is clear he has heard the parent. The concept of matching positive affect may be relevant here. The child classified secure matches and shares the parent's positive affect (the "positive affective sharing" of Waters, Wippman, & Sroufe, 1979); the avoidant child may or may not match the affect, but certainly does not share it (this is done in a covert manner); the controlling child overtly does not match the affect. For instance, if the parent says, "Oh, look at this!" the secure child might respond, "Yeah, the little man goes in there!" and look and smile at the parent. The avoidant child might move away suddenly to get some more toys, indicating that his attention was suddenly called elsewhere, thereby preventing him from responding, or he might make a minimal response, "Yeah." The controlling-punitive child might simply continue her ongoing activities, with neither a response nor an attempt to hide the lack of a response.

controlling-general: Children in this group have taken control of the interaction, but it is not possible to identify either a clear caregiving or a clear punitive quality. Both forms of controllingness, or neither, may be present. A child who simply gives the parent a long list of commands, or who directs or structures the interaction without being either particularly hostile or caregiving, would be classified here.

Main & Strage (1988) have described the discourse patterns of controlling 6-year-olds and their parents as being dysfluent and containing false starts. The parent questions the child, and the child controls the conversation. The focus of the conversation is often on the relationship. We have noted similar patterns in 2 1/2- to 4 1/2-olds.

disorganized: These children show signs of disorganization similar to those described by Main & Solomon (1986) in infants. Although the specific behaviors of 2 1/2- to 4 1/2-year olds are different from those of infants, the underlying qualities are similar, and include: disordering of expected temporal sequences (e.g., strong avoidance followed by strong proximity-seeking), incomplete or undirected movements and expressions (including stereotypies), direct indices of confusion and apprehension, dazed and disoriented expressions, and indices of depressed affect. (Additional signs of disorganization identified by Main & Solomon in infants, but not yet seen in 2 1/2- to 4 1/2-year olds, include simultaneous display of contradictory behavior patterns, and behavioral stilling. See Appendix VIII for a detailed list.

from Main & Solomon [1986], of direct indices of disorganization and disorientation during the infancy strange situation.) In our experience, some of the children who display behavioral sequences out of the expected order and/or indices of confusion turn out to be children with minimal neurological impairments, or neurological "soft signs." These children, who may number as many as one in every 15-20 children in "normal" samples, are often labelled as learning disabled when they reach school-age. Some of these children clearly can be classified in some other, secure or insecure group, whereas others seem best to be placed within this disorganized subgroup.

Note: When children are classified insecure/controlling-disorganized (or insecure/other), the underlying ("or forced") classification should also be provided, following a procedure suggested originally in relation to infants by Main & Solomon (1986). Although disorganized/disoriented infants very seldom meet the criteria for placement in any single secure, avoidant, or ambivalent category, a best-fitting alternative secure, avoidant, or ambivalent category can usually be assigned, and has been considered meaningful in terms of external correlates (see Main & Hesse, 1990). Main & Solomon have proposed, therefore, that infancy researchers continue to use the full information available to them in the infant's strange situation behavior, retaining the infant's alternative classification for analysis. Thus, following a practice already used by Main & Cassidy with six-year-olds (1988), we suggest that children who are coded either insecure/controlling or insecure/other be also assigned a best-fitting alternative secure, avoidant, or ambivalent category as well (e.g., controlling/forced secure- reserved, or insecure-other/forced avoidant).

Insecure-other

Children who are judged insecure on reunion with the parent, but do not fall into any of the three identified insecure categories are classified here. In addition, some children show behavior patterns common to more than one category, and forcing a decision which would place the child into one of these categories would result in the omission of important information. We encourage the coder to place children who show combinations of behavior patterns from more than one category here, and to note the combinations. This would allow us to determine whether important combinations occurred with sufficient frequency to merit demarcation as separate and/or new classificatory groups or subgroups. (Note that this coding practice differs from that used by Main & Solomon with infants [1986]. Here, a child with both avoidance and resistance would be coded "Insecure-other." With Main & Solomon's infancy system, such a combination of behaviors would result in a classification of "Disorganized.")

The issue of how far a child's behavior can deviate from the behaviors described here as characteristic of a particular group, before being classified insecure-other, must be considered. Clearer understanding of the ranges of "classifiable" behavior patterns will come once the coder has had extensive experience viewing children in this procedure. Certainly, the behavior of most children will permit classification in one of the other attachment groups. Less than 5% of children from normal samples are expected to be placed in this group. Children from special populations, e.g., children who have experienced physical or sexual abuse or who have neurodevelopmental problems, may be more likely than other children to exhibit combinations of behaviors resulting in placement here. Some of these children whose behaviors do not readily fall into other categories show sexualized behavior or depressed behavior in relation to the parent.

For purposes of data analysis, children in this group may be combined with children from the Insecure/Controlling group.

Summary of Criteria for Attachment Group

Table 2 (next page) provides a summary of behaviors across modalities for each attachment classification group. It is not only the frequency of discrete behaviors that is important, but also context, timing, quality, and patterning. The presence or absence of any single behavior or any set of behaviors does not determine attachment classification. The existence of particular patterns across the situation as a whole determines attachment classification.

TABLE 2

OUTLINE OF CRITERIA FOR ATTACHMENT GROUPS

	SECURE	AVOIDANT	AMBIVALENT	CONTR/DISORG
PROXIMITY/ CONTACT	--Immediate or gradual increase in proximity --C may initiate comfortable, casual contact or more intimate contact. --C accepts P's contact. --Contact is not aggressive, controlling or ambivalent. --Contact may be brief.	--Little or no increase in proximity. --Increase in distance. --Proximity only for "business," e.g., fixing toys, or with concern about P's availability. --Hostile or aggressive contact, usually in guise of play.	--Ambivalent contact, e.g., standing near P while facing away, leaning against P's back, hanging on P in a "helpless" way. --Some C's initiate intimate contact, e.g., sitting on P's lap.	--Some C's show aggressive or hostilely controlling contact. --Perhaps an initial burst of affectionate proximity- or contact-seeking. --Some show not interest in proximity/contact. --Some C's may dash away from P on reunion.
BODY ORIENTATION	--C orients toward P. --C may lean toward P. --C and P may be in close face-to-face position.	--C may orient away from P. --C uses body orientation to focus attention away from interaction. --When oriented to P, C may respond to P's initiation; when oriented away, C may not respond.	--Some C's display moderate avoidance. --Some C's are in face-to-face orientation with P.	--Even when oriented to P, C may "refuse to answer" P. --C may orient to P in the context of "care-giving" behavior.
SPEECH	--C initiates &/or maintains interaction through speech. --Speech may be personal, intimate, comfortable and fluid. --C is eager to discuss his activities, and may invite P to join in play. --C may show interest in P's thoughts, feelings, activities, etc.	--Minimal speech from some C's. --From some C's, speech expansions accompanied by other, avoidant behavior. --From some C's, "running commentary" which functions to minimize reciprocal dialogue. --Conversations tend to be impersonal and often lacking in smooth turn-taking.	--Some C's engage in fruitless arguments with P. --Some C's insist on having their own way in a whining tone. --Some C's whisper in a "helpless" fashion.	--Some C's are punitive, hostile controlling of P; some refuse to answer P's initiative. --Some C's are overly "cheery" &/or "bright."
GAZE	--C looks at P soon after reunion begins. --C looks at P readily and comfortably at appropriate times. --Full, open, direct &/or lingering gazes.	--Delay in looking at P on reunion may be substantial. --consistent lack of glances/looks at P at times they would be expected. --Essentially no full, open, direct or lingering gaze at P.	--Moderate gaze avoidance.	
AFFECT	--C displays interest in P's return. --C's affect is positive: warm smiles, appropriate laughter. --disagreements are negotiated with a minimum of negative affect. --Affect is neither overly-bright or overly-dull. --Changes in expression are smooth rather than abrupt. --C matches affect-level of P. --Comfort prevails.	--Neutral and/or tense affect. --Perhaps a brief "social" smile on greeting. --If P presses for interaction, C may respond with giggles &/or other nervous behaviors, as if uncomfortable with the attention. --Expressions often seem controlled &/or overly-abrupt transitions from one expression to another.	--Some C's are petulant, tantrumy, negative, &/or argumentative. --Some C's display big, "toothy" grins; false smiles. --Some C's display a helpless, whispering, fragile affect. --Pleasant affect may be interspersed with negativity.	--Some C's are punitive, hostile, controlling of P. --Some C's "overbright," excessively cheery. --Does not match P's affect; C attempts to either lift or dampen P's affect. --Some C's show depressed affect, confusion, or apprehension.

Rating Scales

At present, there are two rating scales: a 9-point scale of security of attachment, and a 7-point scale of avoidance. These scales are not designed to be independent. For instance, a high score on the avoidance scale necessitates a low score on the security scale; however, a low score on the avoidance scale is congruent with either a low or a high score on the security scale.

We view these rating scales as having important conceptual and practical relations to the classification system. Conceptually, the classification system is based on a nominal scale while the ratings are continuous. This mixture is appropriate in that the ratings reflect the additional fact that there are, indeed, degrees of security, avoidance, etc., within each of the discrete classificatory (sub)groups. Practically, classifying a child within a particular subgroup, and assigning that child a rating on each of the scales, allows one to make more fine-grained distinctions within a given subgroup. The use of ratings also facilitates correlational analyses of the relation between particular subgroups and other, usually continuous, variables.

Avoidance Scale

This scale is designed as a 7-point scale for easy comparison with Ainsworth's 7-point strange situation avoidance scale.

1. No avoidance

3. Brief but limited, or persistent but faint avoidance

5. Brief but strong avoidance, or persistent low-keyed avoidance

7. High avoidance: extreme neutrality

The instructions for coding avoidance given in Main & Cassidy's (1987) manual for use with six-year-olds are also useful for 2 1/2- to 4 1/2-year-olds. These instructions include three sections: a) Indications of avoidance; b) Forms of greetings, speech, and proximity-seeking consonant with high avoidance; and c) Forms of greetings, speech, and proximity-seeking inconsonant with high avoidance. Up to this point, we have seen no need to modify this avoidance scale for use with children in this younger age range. It is possible that changes may need to be made in the future, based on a clearer understanding of how avoidant behaviors develop across this age span. This scale is useful when there is a particular conceptual interest in avoidance (e.g., for the examination of stability of avoidance, or of the theoretically predicted correlates of avoidance).

The section on avoidance from the sixth-year coding manual (Main & Cassidy, 1987) is included with these guidelines as Appendix IX.

Security Scale

Defining points are from the scale for rating security in six-year-olds from Main & Cassidy (1987), but relevant specific behaviors may be different.

9. Highly Secure: Initiating

This score is given to children who initiate interaction, proximity, or contact with complete ease and unambivalence. The child indicates that his relationship with this parent is a special one. The child is particularly calm, yet at the same time clearly pleased, on reunion.

7. Secure: Responsive

This score is given when the child is responsive to the parent, and indicates through any of a variety of ways that this is a special relationship. There is some reason, however, that the highest score is not given: perhaps a bit of initial reserve, or slight attempts to control the parent.

5. Probably Secure

This score is given when there are indications of both security and insecurity, but on balance, the child seems secure. This score is given a) when there are clear signs of neither security nor of insecurity, or b) when there are signs of both security and insecurity.

3. Insecure

This score is given when the child is either avoidant, ambivalent, controlling, or disorganized. However, there is some slight indication of security within the child's relationship with the parent.

1. Highly Insecure

This score is given when the child is either highly avoidant, highly ambivalent, highly controlling, highly disorganized, or shows a combination of more than one strategy.

Scores of 2, 4, 6, and 8 may, of course, also be given.

The connections be the security scale and the attachment classifications are as follows:

classification	security scale score
avoidant-ignoring	1-2
avoidant-neutral	2-4.5

very secure	7.5+
other secure subgroups	5-7.5
all ambivalent and controlling subgroups	1-4.5
insecure-other	1-4.5

When security scale scores are assigned, the attachment clasification should first be assigned. The security scale scores then allow for further gradations of assessment of security vs. insecurity. There should be a match between scale score and classification: if a coder assigns a high scale score along with a classification of insecure, the coder has made a mistake.

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Appendix I

Strategies associated with A, B, and C Attachment Patterns

Main (1981) and Main & Weston (1982) have discussed the secure, avoidant, and ambivalent-resistant attachment categories in terms of coherent attachment strategies. The strategy refers to the means the infant uses in organizing behavior relevant to attachment. Main, Kaplan, & Cassidy (1985) have discussed the "internal working models" associated with these attachment patterns. Main & Solomon (1986) provided the following summary:

> (1) The *secure* infant has a clearly coherent strategy focused upon the use of the attachment figure as a secure base. This results in a steady alerting of the need to increase proximity in strange environments or in the face of separation, and a ready return to exploration once assured that the attachment figure is once again available. For these infants, there is a relatively smooth alternation between attachment behavior and exploratory behavior with one or the other receiving emphasis, dependent upon the accessibility of the attachment figure and the initial "strangeness" of the situation.
>
> (2) The *avoidant* infant also has a coherent and organized strategy. For this infant, exploration is emphasized over and above attachemnt behavior, and specificity of relationship to the attachemnt figure is de-emphasized. In the strange situation, these infants seem successfully to divert attention from both the attachment figure and many environmental changes which act to increase attachment behavior in other infants (Bowlby, 1980; Main, 1981). Consequently, these infants engage in exploration throughout separation, are friendly to the stranger and/or may treat him or her more favorably than the mother, and actively avoid the parent upon reunion. It is likely through consistent use of an attention-diverting strategy (above) that the avoidant infant "ignores" separation from as well as the return of the parent. The impression given by the strange situation behavior of these infants is largely one of detachment and of a defensive, but successfully un-interrupted independence.
>
> (3) Finally, the *ambivalent-resistant* infant may be seen as having a coherent strategy of exhibiting extreme dependence upon the attachment figure. Exaggerated fear of the strange, the stranger, and separation is combined with heightened distress and anger. In its heightened display of emotionality and dependence upon the attachment figure (cf. Trivers, 1974; Main, 1981), this infant successfully draws the attention of the parent.

Appendix II
Patterns of Parental Behavior

Note: The parental behaviors described here are not used as a basis for classifying the child's attachment. Any of these behaviors might be present in any parent. It is the recurring appearance of these behaviors, and the particular context in which they occur, that is characteristic of parents of particular groups of children. In the final analysis, it is the child's response to these behaviors that is the basis of classification. We include this material here only in the spirit of reporting potentially interesting observations.

Parents of secure children tend to be warm, available, and responsive. Whether demonstrative, casual, or slightly reserved, they enjoy their children, and tend to initiate either casual and comfortable conversation or physical proximity or casual contact. They respond readily to bids for comfort, but are approving/encouraging of a return to play once the child has been comforted. They do not ask for comfort for themselves. These parents are comfortable setting limits on the child, and in maintaining control of the relationship if the child makes inappropriate attempts to control the parent. They are clear and direct in their communications with the child.

The behavior of parents of avoidant children is consistent with a strategy of minimizing the importance of attachment relationships. These parents can appear cool and distant. They tend not to approach the child, and not to initiate physical contact or personal interaction. They may orient away from the child. They may appear detached, and offer little warmth in the relationship. These parents may speak more with the experimenter than with the child.

The behavior of parents of ambivalent children is consistent with a strategy of emphasizing the importance of attachment relationships. These parents may pull for the child to emphasize how dependent she is on the parent. They may signal, either overtly or subtly, for the child to come for a hug when the child herself is showing no interest in proximity or contact. Some parents seem particularly aware of the child's nearness, and if the child comes within a set proximity, hold out their hands in an inviting way, non-verbally beckoning the child to come closer for contact. These parents may repeatedly emphasize the closeness or similarity of parent and child (e.g., "Do you want to put your sweater with mine?"; "You like chocolate just like me"; "Let's do it the same way"). Parents of ambivalent children respond readily to bids for comfort or contact, and are particularly content to remain close with the child. They are either not particularly interested in returning the child to the toys, or not particularly adept at doing so. In either case, they do not help focus the child's attention to the environment. These parents are often not skillfull in resolving either conflict or distress, allowing it to drag on and on. These parents may become embroiled in arguing with their children. They may have difficulty setting limits.

Some of these parents have difficulty leaving their children. One outcome of the parent's prolonging the leave-taking is that she hears the child repeatedly protest her departure, and repeatedly emphasize how much he wants to be with her. Some parents, when a child shows little protest on leave-taking, may even repeat their intention of leaving until eventually the child begins to cry. These parents may also emphasize the child's dependency by, on reunion, returning to the issue of the child's previous distress.

Some parents may be quite hostile and sarcastic. They may mock the child's separation distress, while showing their interest in prolonging and discussing this distress in other ways.

Some parents of children classified insecure/disorganized tend to emphasize their own need for care. They may relegate some of the responsibility for their own well-being to the child. They may seek direct comfort from the child, or may suggest, perhaps playfully, that the child take care of them. These parents may either make the child into an adult partner/playmate, or behave as a child playmate themselves. Main & Hesse (1990) have proposed that the caregiving system of these parents may have become disorganized by loss or other traumatic events.

Other parents of these children seem withdrawn, "spacey", unpredictable, or aggressive toward their children.

These parents may have difficulty with affect regulation, seeming either somewhat flat or overly cheery. Conversation may be dysfluent.

Appendix III
Main's inductive method of development of new classification systems

The following, taken from Main & Cassidy (1988), describes the way in which those authors used knowledge of infancy attachment classifications in the development of their 6th-year system. A similar process was used in the development of the present system. (For a more detailed description of this procedure, see Main, in press.)

Development of the Sixth-year Classification System

A judge who was well-informed with respect to infant attachment classification in general, but who was blind to the infant attachment classifications for this [Berkeley] sample studied reunion responses across the sample as a whole and then (one-by-one) studied each child's reunion response in an attempt to guess the probable infant attachment classification with a given parent. The sixth-year system was gradually developed from this case-by-case study. Both rationales regarding a correct guess ("match") and information regarding the actual infancy categories of sixth-year misses ("mismatches") were used in developing the sixth-year system.

This inductive, "guess-and-uncover" method of development of new classification systems has been discussed in detail elsewhere (Main, in press). The method relies conceptually upon the presumption that there will be some attachment-related predictability to behavior in samples (such as the Berkeley sample) in which major life-changes and stresses have not interfered with ongoing interaction patterns. However, the method cannot lead empirically to the inflation of actual levels of predictability. An observer who attempts to identify the early attachment organization of a new individual on the basis of provisional rules being constructed to describe commonalities observed in the behavior of several previously observed individuals will mis-identify that individual if:

(a) there is in fact no order, lawfulness, or connection between response to reunion at one and at six years; or if

(b) there is lawful connectedness but accurate rules have not been developed, or if;

(c) accurate rules have been developed for the sixth-to-first-year equivalencies across the sample of six-year-olds as a whole, but this particular individual has changed in attachment organizations over the five-year period.

In other words, a "match" will not be made if in fact the relation between first-year and sixth-year behavior is chaotic or incorrectly identified, nor will it be made if the new individual belongs to the minority of children in the sample who have changed in attachment organization. The true first-to-sixth-year changes of attachment organization that occur in the minority of cases in such a sample will be accurately represented in the judge's failure to correctly identify the six-year-old's infancy pattern. "Matches" (first to sixth-year associations) will occur beyond the chance level only if most A, B, C and D infants do show the behavioral transformations expressed in the developing rule system.

As the system was first being developed, a number of correct guesses ("matches") were readily made. For example, a child who craned her head around to smile at the mother, chattered to mother about her experiences of the last hour, and invited the mother to play was correctly identified as having been secure with mother in infancy, and succeeding children who responded similarly to reunion with the parent were then correctly identified as having been secure with that parent in infancy. Misses ("mismatches") were also utilized in system development. For example, the first child seen to fail to speak in response to the parent's increasingly frantic conversational overtures was identified as a child who had been avoidant of the parent as an infant. When this guess proved incorrect (the child had been disorganized/disoriented), we reviewed the reunion behavior of children who had correctly been identified as insecure-avoidant in infancy and discovered that avoidant children were at least minimally responsive to the parent when pressed, giving brief answers (e.g., "What's that nice-looking set of toys you've been playing with?" "Sandbox"). Succeeding six-year-olds who confrontationally refused response to a particular parent (e.g., "Let me ask you again. What's that nice-looking set of toys you've been playing with?" "...") were considered more likely to have been disorganized/disoriented with that parent in infancy. A new, "controlling-punitive" response category was gradually developed and separated from the "insecure-avoidant" and "secure" response categories.

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Appendix IV

Summary of Episodes of Ainsworth's strange situation

(from Ainsworth et al., 1978)

TABLE 3
Summary of Episodes of the Strange Situation

Number of Episode	*Persons Present*	*Duration*	*Brief Description of Action*
1	Mother, baby, & observer	30 secs.	Observer introduces mother and baby to experimental room, then leaves.
2	Mother & baby	3 min.	Mother is nonparticipant while baby explores: if necessary, play is stimulated after 2 minutes.
3	Stranger, mother, & baby	3 min.	Stranger enters. First minute: Stranger silent. Second minute: Stranger converses with mother. Third minute: Stranger approaches baby. After 3 minutes mother leaves unobtrusively.
4	Stranger & baby	3 min. or less[1]	First separation episode. Stranger's behavior is geared to that of baby.
5	Mother & baby	3 min. or more[2]	First reunion episode. Mother greets and or comforts baby, then tries to settle him again in play. Mother then leaves, saying "bye-bye."
6	Baby alone	3 min. or less[1]	Second separation episode.
7	Stranger & baby	3 min. or less[1]	Continuation of second separation. Stranger enters and gears her behavior to that of baby.
8	Mother & baby	3 min.	Second reunion episode. Mother enters, greets baby, then picks him up. Meanwhile stranger leaves unobtrusively.

[1] Episode is curtailed if the baby is unduly distressed.

[2] Episode is prolonged if more time is required for the baby to become re-involved in play.

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Appendix V
Modified Ainsworth Strange Situation for Preschool Children
(from Marvin & VanDevender, 1978)

Ep 1. (3 minutes) Warm-up: Parent and child are in the playroom together.

Ep 2. (3 minutes) Separation 1: The parent leaves the room; the child remains.

Ep 3. (3 minutes) Reunion 1: The parent returns.

Ep 4. (6 minutes) Separation 2: The parent leaves the room; the child remains.

Ep 5. (5 minutes) Reunion 2: The parent returns.

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Appendix VI
Instructions for the parent

[These instructions are for the modified strange situation procedure described in Appendix IV. Instructions for Ainsworth's strange situation follow the same format, with the necessary changes.]

In this part of the study, we are examining children's responses to brief separations from parents. Our focus is on your child. We are giving you these instructions in a written format because we do not want to talk about the procedure in front of the child.

When you have finished reading these instructions, I will take you into the playroom. The session is divided into five parts:

1. You and your child will be in the playroom about 3 minutes. Both of you can do whatever you'd like. However, we would like you to remain in your chair when possible whenever you are in the playroom.

2. After about 53minutes, there will be a signal (describe it), and that will be your signal to leave the playroom. [Then, either: We'd like you to let your child know that you have to make a phone call and that you'll be back. We would like your child to stay in the playroom.]
[or: We'd like you to leave the room however you'd like. The only thing we ask is that your child stay in the room. We will have a question form that we would like you to look at while you are out of the room if there's time.]

3. After three minutes, we will send you back in the room.

4. After you have been back in the room several minutes, there will be a second signal, and again, you should leave the room in the same manner as previously. Your child should remain in the playroom.

5. You will again stay out of the room for 6 minutes this time, and then return.

If, when you are gone, your child gets distressed and you would like to return early, that is fine. Just let us know. [if parent is in hall: You will be able to hear your child from the hall. In addition, the videotaper will notify you if your child is distressed.]

These instructions may seem confusing. You do not have to remember all of these instructions. We will give you instructions as you go through the session.

What you do need to remember now is:
listen for the first signal, about 3 minutes after you've been in the room, and leave then [state how].
Your child should stay in the room.
I'll be out here waiting for you, and will remind you of what comes next.

Appendix VII
Recomendations for use of the scoring system

The behaviors of 2 1/2- to 4 1/2-year-olds are much more complex than those of infants, and for that reason, inter-rater reliability is typically lower with this system than it is with Ainsworth's infancy coding system. We strongly suggest that all separation/reunion procedures be coded independently by two well-trained coders (who have achieved reliability with the MacArthur Attachment Working Group reliability tape), and that differences be conferenced or resolved by a third coder.

The coder should have as much information about the procedure as possible. She should know what procedures, if any, precede the separations/reunions, and what instructions the parent was given. She must also know the child's age.

We suggest that the coder preview at least a dozen of the set of reunions before scrutinizing each reunion separately.

When viewing a reunion, the coder should pay special attention to the 30 seconds prior to the moment of reunion. This enables the coder to gague any shifts in the child's behavior brought on by the parent's return. Coders should think about the child's general organization right before and right after the parent's entrance -- especially the degree to which the child can integrate smoothly the parent's entry, or must reorganize himself to deal with some disruption caused/(re)activated by the parent's entry.

We suggest that the coder take extensive notes of the relevant behaviors while watching the tapes. A procedure developed by Lisa Berlin, a Penn State graduate student, has worked well: Following extensive notes, the coder fills in two pages of forms (attached). Any system which helps the coder remember and organize relevant behaviors can be useful.

Possible Coding Sheets

Modality	Description
proximity	
body orientation	
speech	
gaze	
affect	

pg. 2, coding sheet

avoidance rating scale: ____________
rationale:

security rating scale: ____________
rationale:

classification: ____________
alternate: ____________
confidence (from 1, low to 5, high): ____________
rationale:

Appendix VIII

from: Main, M., & Solomon, J. (1990). Procedures for identifying infants as disorganized/disoriented during the Ainsworth Strange Situation. In Greenberg, M., Cicchetti, D., & Cummings, E. M. (Eds.), Attachment in the Preschool Years: Theory, Research, and Intervention (pp. 134-146). Chicago IL: University of Chicago Press.

INDICES OF DISORGANIZATION AND DISORIENTATION

Table 1 represents an attempt to order examples of the various types of disorganization and disorientation in behavior seen in the Strange Situation under seven thematic headings: (1) sequential display of contradictory behavior patterns; (2) simultaneous display of contradictory behavior patterns; (3) undirected, misdirected, incomplete, and interrupted movements and expressions; (4) stereotypies, asymmetrical movements, mistimed movements, and anomalous postures; (5) freezing, stilling, and slowed movements and expressions; (6) direct indices of apprehension regarding the parent; and (7) direct indices of disorganization or disorientation. The headings are selected for heuristic purposes and are not mutually exclusive. Some patterns could be placed equally well under several headings, for example, a fearful smile directed to the parent at entrance could be described either as an instance of "simultaneous exhibition of contradictory behavior patterns" or as a "direct index of apprehension."

Sequential Display of Contradictory Behavior Patterns

One of the most striking types of disorganized/disoriented behavior occurs in the form of quick displays of contradictory behavior patterns, such as strong displays of attachment behavior succeeded almost immediately by avoidance. Avoidance, an "organized shift of attention" away from the parent (Main & Weston 1982), is a relatively frequent response to separation. With respect to the Strange Situation, avoidance *followed by* proximity seeking, either in response to assurance that the parent intends to remain with the infant in a given reunion or in response to a second separation and reunion, is seen as a natural sequencing of events and is associated with a mildly avoidant "secure" subcategory of Strange-Situation behavior (subcategory *B2*; see Ainsworth et al. 1978). In these contexts, avoidance can be understood as "reserve." Such reserve may be seen as having "melted" with time over the course of a single reunion episode, or as "breaking down" across two reunion episodes in response to a second leave-taking. To most observers, there is nothing inherently disorganized in this sequencing, despite the shifts which occur in behavior.

Consider now in contrast the temporal organization of behaviors described as *disorganized* in table 1. In an earlier paper, we described these unexpected shifts as a "disordering of expected temporal sequences" (Main & Solomon 1986).[4] Rather than avoiding the parent upon reunion for a few seconds, and then gradually initiating interaction or contact, some infants give the parent a full greeting with raised arms and active bids for contact, then suddenly succeed this search for contact with avoidance. Others show high

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[3] Our review of these sixty classifiable (*A*, *B*, *C*) videotapes took place in 1985, before any efforts toward assigning *D*-scale values had been devised. While there is no doubt regarding the greater intensity and frequency of *D* behaviors in the thirty-four unclassifiable tapes, it is possible that a current review of these tapes would now lead to an estimate of a somewhat higher overall proportion of *D* classifications within our sample.

[4] Originally, we described patterns similar to these as exemplifying a "disordering of expected temporal sequences." We are grateful to Bryan Cowley for suggesting "sequential display of contradictory behavior patterns" as a heading referencing a more inclusive array of examples.

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TABLE 1 INDICES OF DISORGANIZATION AND DISORIENTATION
(For Infants 12 - 18 Months Observed with Parent Present)

1 *Sequential Display of Contradictory Behavior Patterns*

Very strong displays of attachment behavior or angry behavior suddenly followed by avoidance, freezing, or dazed behavior. For example:

- —In the middle of a display of anger and distress, the infant suddenly becomes markedly devoid of affect and moves away from the parent.
- —*Immediately following strong proximity seeking and a bright, full greeting with raised arms, the infant moves to the wall or into the center of room and stills or freezes with a "dazed" expression.*
- —*Infant cries and calls for the parent at the door throughout separation; immediately upon reunion, however, the infant turns about and moves sharply away from the parent, showing strong avoidance.*

Calm, contented play suddenly succeeded by distressed, angry behavior. For example:

- —*Infant calm and undistressed during both separations from the parent, but becomes extremely focused upon the parent, showing highly distressed and/or angry behavior immediately upon reunion.*

2. *Simultaneous Display of Contradictory Behavior Patterns*

The infant displays avoidant behavior simultaneously with proximity seeking, contact maintaining, or contact resisting. For example:

- —While held by or holding onto parent, infant shows avoidance of parent such as the following: (*a*) infant sits comfortably on parent's lap for extended period but with averted gaze, ignoring parent's repeated overtures; (*b*) infant holds arms and legs away from the parent while held, limbs stiff, tense, and straight; (*c*) infant clings hard to parent for substantial period while *sharply* averting head/gaze. (Note: Disorganized only if infant is clinging hard while sharply arching away. Many infants look away or turn heads away while holding on lightly after a pick-up.)
- —Infant approaches while simultaneously creating a pathway which avoids and moves away from parent, and this cannot be explained by a shift of attention to toys or other matters. Thus, from its inception the infant's "approach" seems designed to form a parabolic pathway.
- —*Movements of approach are repeatedly accompanied by movements of avoidance such as the following:* (a) *infant approaches with head sharply averted,* (b) *infant approaches by backing toward parent,* (c) *infant reaches arms up for parent with head sharply averted or with head down.*
- —*Distress, clinging, or resistance is accompanied by marked avoidance for substantial periods, such as the following:* (a) *infant moves into corner or behind item of furniture while angrily, openly refusing or resisting parent;* (b) *infant cries angrily from distance, while turning in circles and turning away from parent.* (Note: Arching backward with flailing arms, and throwing self backward on floor are part of normal infant tantrum displays and are not necessarily considered disorganized.)
- —*Extensive avoidance of parent is accompanied by substantial distress/anger indices, such as: infant silently averts head and body away from parent who is offering or attempting pick-up but makes stiff, angry kicking movements and hits hands on floor.*

Simultaneous display of other opposing behavioral propensities. For example:

- —Infant's smile to parent has fear elements (*very strong index* if marked, see no. 6).
- —*While in apparent good mood, infant strikes, pushes, or pulls against the parent's face or eyes. (These usually subtle aggressive movements are sometimes immediately preceded by a somewhat dazed expression, or may be accompanied by an impassive expression.)*

3. *Undirected, Misdirected, Incomplete, and Interrupted Movements and Expressions*

Seemingly undirected or misdirected movements and expressions. For example:

- —Upon becoming distressed, infant moves away from rather than to parent. (Note: Do not consider brief moves away from parent disorganized when an infant has been crying and displaying desire for contact for a long period, and parent has failed to satisfy infant. Infant may briefly move away while crying in response to frustration in these circumstances, coming back to parent to try again, without being disorganized.)
- —Infant approaches parent at door as though to greet parent, then attempts instead to follow stranger out of the room, perhaps actively pulling away from the parent. (This pattern seems more misdirected or redirected than undirected; see no. 7 for similar behavior.)
- —Initiation of extensive crying in parent's presence without any move toward or look toward the parent. (Note: This is not necessarily disorganized if parent is already nearby and attentive. It also is not disorganized if the infant, having already been crying and focused on the parent for an extended period, simply does not look at or move closer to the parent for a few seconds.)
- —Any marked failure to move toward the parent when path is not blocked and infant is clearly frightened.
- —Similarly, expression of strong fear or distress regarding an object while staring at it, without withdrawing from it or looking toward parent.
- —*Extensive or intense expressions of fear or distress accompanied or followed by moves away from rather than to parent, as, infant appears frightened of stranger in parent's presence, moves away and leans forehead on wall.*
- —*Infant cries at stranger's leave-taking, attempts to follow her out of room. (This behavior pattern may be more misdirected or redirected than undirected; see also no. 7.)*

Incomplete movements. For example:

- —Movements to approach parent are contradicted before they are completed, for example, infant moves hand toward parent and withdraws hand quickly before touching parent, without rationale. Or repeated, hesitant, stop-start approach movements (or reach movements) toward parent.
- —Exceptionally slow or limp movements of approach to parent, as though the infant is resisting the movements even while making them ("underwater" approach movements).
- —*Exceptionally slow, limp, movements of striking at, pushing at, or pulling at the parent's face, eyes, or neck ("underwater" movements). The subtle but definite aggressive intent is almost indiscernible because of the incomplete, slow nature of the movements.* See also 5.

Interrupted expressions or movements. For example:

- —After a long period of contented play, sudden out-of-context crying or displays of distressed anger without rationale.
- —*Infant interrupts approach to parent on reunion with a bout of angry behavior, directed away from the parent, then continues approach. As, begins strong approach upon reunion but interrupts approach to look away and strike hand on floor with angry sounds, then completes full approach.*
- —*Infant rises or begins approach immediately upon reunion, but falls prone in "depressed" (huddled) posture.*

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TABLE 1 *(continued)*

4. *Stereotypies, Asymmetrical Movements, Mistimed Movements, and Anomalous Postures*

Asymmetries of expression or movement. For example:

—Asymmetries of movement on approach to parent (asymmetrical creeping, heavy or fast on one side only), with or without sudden, unpredictable changes of direction.

—Asymmetries of facial expression directly upon the appearance of the parent, for example, an extremely swift "tic" which lifts only the left side of the facial musculature.

Stereotypies. For example:

—Extended rocking, ear pulling, hair twisting, and any other rhythmical, repeated movements without visible function. (Note: Do not include "stereotypies" that make sense in the immediate context, as rubbing eyes in a tired infant, or some initial ear pulling or hair pulling in the stranger's presence).

—Marked stereotypies while held by the parent. (Do *not* include rubbing eyes if infant has been crying, or brief continuation of previous stereotypies while in arms in an infant who showed the same stereotypies during separation.)

Assumption of anomalous postures. For example:

—*Repeated assumption of uninterpretable postures, as, head cocking with arms crooked over head.*

—*Assumption of huddled, prone, depressed posture for more than twenty seconds, unless infant is clearly tired.*

—Any posture stereotyped for a particular baby, as, closing eyes and holding hands forward at shoulder height for several seconds in response to each reunion.

Mistimed movements. For example:

—Unpredictable bouts of activity or movement which seem to lack normal preparation time for initiation, and/or which have a jerky, automaton-like (unmonitored) quality. For example, a sudden burst of jerky arm and leg activity in an infant who had been sitting tense and immobilized a second prior.

5. *Freezing, Stilling, and Slowed Movements and Expressions*

Freezing is identified as the holding of movements, gestures, or positions in a posture that involves active resistance to gravity. For example, infant sits or stands with arms held out waist-high and to sides. *Stilling* is distinguished from freezing in that infant is in comfortable, resting posture which requires no active resistance to gravity. Freezing is considered a stronger marker of disorientation than stilling.

Freezing and stilling suggestive of more than momentary interruption of activity. For example:

—*Freezing lasting twenty seconds or more, and stilling lasting thirty seconds or more, accompanied by dazed or trance-like facial expression. For example, freezing accompanied by tense, smooth closing of the lids or by lifeless stare.*

—*Interrupting a bout of resistant or distressed behavior, freezing (ten or more seconds) or stilling (twenty or more seconds) is accompanied by a dazed or trance-like expression.*

—*Freezing lasting twenty-five seconds or more, and stilling lasting thirty-five seconds or more, while held by parent unless infant has recently been engaged in hard crying (below).* (Notes: [1] Context should be considered. [2] Do not consider stilling during the first thirty seconds of reunion if the infant is being held by parent, has been crying hard, and is clearly simply in transition from crying. [3] Infant should not be considered to be freezing or stilling if infant is watching something with lively interest, as, watching stranger demonstrate working of a toy. [4] The C2 infant is passive by definition; general passivity should not be confused with stilling.)

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TABLE 1 *(continued)*

Slowed movements and expressions suggesting lack of orientation to the present environment. For example:

—Markedly apathetic or lethargic movements, as though infant is without purpose in moving forward.

—Slack, depressed, dazed, or apathetic facial expression especially when unexpected, as accompanying approach to parent on reunion ending in raised arms. (Note: Consider only expressions specified above. Neutral or impassive expressions are not considered indicative of disorientation with respect to the current environment.)

6. *Direct Indices of Apprehension Regarding the Parent*

Expression of strong fear or apprehension directly upon return of parent, or when parent calls or approaches. For example:

—*Immediate responses to noting parent's entrance such as the following:* (a) *jerking back, with fearful expression;* (b) *flinging hands about, over, or in front of face, or over mouth, with fearful expression;* (c) *dashing away from the door/parent upon reunion, with hunched or tucked head and shoulders.*

—Other expressions of fear or apprehension soon following reunion, such as *fearful facial expression on pick-up.*

Other indices of apprehension regarding the parent. For example:

—Moving behind chair or behind furniture without immediate rationale (pursuit of toy, interest in object behind chair, or brief exploration), especially when infant is then out of reach or out of sight of parent.

—Following a hesitant, seemingly cautious approach to the parent with a rapid, tense "away" movement.

—Offering objects to the parent with tense arm and over an unusual distance, as though avoiding parental "reach" space.

—Raising or tensing shoulders when approaching or in contact with parent.

—Highly vigilant posture or appearance when in presence of parent. Movements or posture tense, infant gives impression of being hyperalert to parent even or especially when parent positioned behind her.

7. *Direct Indices of Disorganization or Disorientation*

Any clear indices of confusion and disorganization in first moment of reunion with the parent. For example:

—Raising hand or hands to mouth directly upon the return of the parent without accompanying confused, wary, or fearful expression. (Do not include thumb or finger sucking, putting objects in mouth, or removing objects from mouth. Do not include if hands already near face.)

—*"Greeting" stranger brightly at the moment of reunion with parent, that is, approaching stranger with raised arms immediately as parent enters.* (Note: Distinguish from the bright or happy look to stranger made by many infants at the moment of the parent's return, often accompanied by pointing to parent to further mark the event.)

—*Flinging hands over, about, or in front of face directly upon return of the parent and in clear response to return of the parent.*

—*Raising hand or hands to mouth directly upon the return of the parent with a clearly confused or wary expression.*

TABLE 1 *(continued)*

- *Confused or confusing sequences of very rapid changes of affect in first few seconds of reunion with parent, as, (a) rapid movement of withdrawal (b) accompanied by confused cry-laugh (c) succeeded by approach movement.*

Direct indices of confusion or disorientation beyond the first moments of reunion with the parent. For example:

- Fall while approaching parent when infant is good walker. Similar unexplained falls when parent reaches for infant, or when parent calls from outside of door.
- Disorganized wandering, especially when accompanied by disoriented expression.
- Rapidly pursuing parent to door, protesting departure, then smiling at door as though in greeting as door closes.
- Disoriented facial expression. Sudden "blind" look to eyes, where infant has previously used eyes normally.

Note. Italics mark very strong indices, which in themselves are usually sufficient for *D* category placement.

distress upon separation, calling and crying for the parent, then backing away immediately upon reunion, their faces suddenly expressionless. They then exhibit strong avoidance.

One of us was able to identify an infant as disorganized/disoriented immediately upon seeing her first reunion episode. The infant went at once to her mother at the door, arms up for contact in a full, strong, "secure" reunion response. She was identified as disorganized, however, when she turned away from the door with a confused, puzzled expression, advanced a few steps into the room, and stood with a dazed look staring straight ahead. This was an abused infant who, on the basis of her strong, immediate proximity-seeking behavior, had been classified as secure within the traditional system.

Simultaneous Display of Contradictory Behavior Patterns

In our review of the literature concerning difficult-to-classify infants, we have already described several instances of the simultaneous display of contradictory patterns. In a previous study, abused infants were described as creeping or walking toward their caregivers sideways, or with head averted, or backing toward them rather than approaching face-to-face (George & Main 1979). Similar behaviors were observed in some *D* infants: for example, an infant in our Bay Area sample "approached" mother by moving backward toward her on her stomach, face averted. Other infants in our sample reached strongly for the parent immediately upon reunion—but with head held sharply down. The impression in each case was that approach movements were being partially but unsuccessfully inhibited through simultaneous activation of avoidant tendencies (see George & Main 1979). Thus, contradictory patterns were activated but were not sufficiently inhibitory to lead to the complete overriding of approach movements.

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An even more striking example of the simultaneous display of contradictory patterns was *avoidance while in contact with the parent*. This appeared in reunion episodes, often after the infant seemed settled from previous distress. Infants who were marked unclassifiable sometimes sat upon the parent's lap—perhaps even comfortably molded to the parent's body—while looking away, either sullen or dazed. One infant seemed comfortable seated on his mother's lap, his body conforming to hers, his arms and hands relaxed. His expression was, however, peculiarly avoidant, and he turned his head away and sullenly, impassively ignored her many overtures. A second baby sat on the floor for several moments with her hand on mother's lap, leaning toward her mother but simultaneously turned slightly away as though intending to approach the toys: silent and trance-like, she failed to turn completely either to the toys or to her mother. A third 12-month-old stood similarly at mother's knee for several seconds looking at the floor, holding onto mother but turned partially away with a dazed expression: face heavy and somber, he seemed unable to play, and unable to seek interaction.

The behavior of these three infants suggests mutual inhibition of the attachment and exploratory behavioral systems. If, comfortably settled on the parent's lap, these infants were not yet ready to return to play, why did they actively refuse the parent's initiations of interaction, or fail to initiate interaction or further contact? And, if the infants were either satisfied with respect to contact with the parent, or preferred to "avoid" the parent by turning attention to exploration of the environment, why were the infants seemingly unable to move away from the parent? Seemingly, these infants could neither respond to the parent, approach the parent, or fully shift attention away.

Undirected, Misdirected, Incomplete, and Interrupted Movements and Expressions

Seemingly undirected, incomplete, and interrupted movements and expressions appeared in many unclassifiable infants. Most examples seemed to involve fear, distress, or aggression, and/or inhibited or interrupted approach movements.

"Undirected" expression of strong fear or distress—that is, strong fear or distress neither accompanied by nor quickly succeeded by physical or communicative orientation to the parent—is one of the strongest markers of the *D* category. One infant appeared frightened of the stranger in the third episode of the Strange Situation, as shown by a high, whimpering cry with mouth corners down and back. Without looking or even slightly orienting toward the parent, she moved away from both the stranger *and* the parent to lean forehead against the wall with a fear-face, her eyes opened widely and cast far to the side. A less extreme example was that of an infant who moved away from his mother to the far side of the room during the first reunion episode. Remaining at this distance, this year-old infant suddenly began a full, continuous cry. While crying, he neither looked at the mother, oriented to her, or undertook an approach movement. Rather, he cried while looking straight ahead of him.

Expressions of anger toward the mother appear in infants in each of the three central Ainsworth categories. In each category, the expression of anger takes a characteristic form. While insecure-avoidant infants do not express anger openly, sometimes they throw a toy at the parent's feet. Strong, direct expressions of anger combined with proximity seeking characterize infants identified as actively insecure-resistant/ambivalent (C1). Finally, secure infants can also express anger toward the mother upon reunion, and in our Bay Area samples infants have occasionally been classified as secure even when an openly frustrated, expressive "swipe" has been taken. For these infants, "hitting at" mother seems a brief, communicative expression of frustration—often at being offered a toy when contact with mother is wanted instead.

Review of our tapes of *D* infants showed an occasional very slow striking at the parent's face, but in incomplete, weak movements which initially appeared undirected and therefore innocuous. Viewing the videotape at normal speed, the movements of the infant's hand might seem, for example, to indicate only an effort to grasp the parent's glasses which had led to accidental jabbing of the parent's face or eyes. That these movements were in fact deliberately directed at the parent's face or eyes—rather than being undirected—could often be inferred from slow motion analysis. In several cases, we observed a change to a dazed, faintly aggressive facial expression just prior to initiation of the slow and apparently undirected aggressive movement.

Proximity seeking was also sometimes interrupted by sudden aggressive movement patterns. The infant of a father who had recently attempted suicide and who was frequently subject to homicidal fantasies provided an especially strong example. During the second reunion, the infant interrupted her strong approach with a simultaneous expression of anger and avoidance. Creeping rapidly forward toward father, she suddenly stopped and turned her head to the side and—while gazing blankly at the wall—slapped a toy and then her empty hand on the floor in a clearly angry gesture, still with head averted and gaze blank. This interruption lasted only three to four seconds. She then continued her strong approach and reached to be picked up. A minute later, while still being held by father, she three times brought her arm down in a gesture that involved apparently accidental striking of father's face with a toy.

This infant's face remained impassive or expressed a good mood on each of these occasions. The child was identified as *D* solely on the basis of the above patterning and without any knowledge of the father's history. Aside from these brief gestures, she appeared secure.

In another example of subtly interrupted, incomplete approach movements, one infant repeatedly leaned toward the mother while standing at her knee but in a slow, heavy manner suggesting that he was resisting and pushing away at the same time. Others approached in an abbreviated, start-

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stop manner, seemingly unable to make smooth forward movements. Two infants quickly approached the parent but then as quickly veered away before arriving beside her, one (below) then sharply rocking on hands and knees.

Stereotypies, Asymmetrical Movements, Mistimed Movements, and Anomalous Postures

Stereotypies and anomalous postures are observed in animals in conflict situations (Hinde 1970) and are also commonly associated with neurological difficulties. The patterns considered here include anomalies of posture such as head cocking; stereotypies such as rocking, ear pulling, hair pulling, and head banging; and asymmetrical or mistimed movements. For example, one infant repeatedly raised both hands to her ears whenever she was hugged by the mother: the mother was later identified as abusive. Another infant approached the mother on reunion, then veered away and rocked violently on hands and knees, facing the wall. These patterns have no obvious orientation with respect to the immediate environment and may have no obvious stimulus. They are often described as "clinical indicators of stress" (Crittenden 1987) and, when seen in medically normal infants, are among those considered most worrisome by observers.

Asymmetrical facial expressions immediately upon hearing or seeing the parent were observed in three infants from maltreating families. The immediate response to reunion observed in one seriously maltreated 12-month-old infant was as follows:

> B hears M's voice and turns and looks to the door. Her look is initially blank, brows somewhat raised. Looks up at M, averts gaze for a moment, facial expression then *divides in two* (left vs. right half of face), uplifting left mouth-corner only. In these microseconds her eyes widen, and as she looks at M, the asymmetry makes her appear puzzled, disgusted or fearful. Her face then breaks into an extremely wide smile.

On the next reunion, this infant showed a fear-smile immediately at mother's entrance.

Mistimed movements appeared in several infants. Three infants crept across the room with highly asymmetrical movements, one hand slapping against the floor belatedly as the other hand made forward progress. Such movements could be interpreted either as the outcome of neurological difficulties, or as the outcome of partial inhibition of approach movement. Whether for reasons of physical or psychological experience, however, mistimed or asymmetric movements occurred largely in infants in maltreatment samples.

Freezing, Stilling, and Slowed Movements and Expressions

Like freezing and stilling, slowed movements and slack, apathetic, or depressed facial expressions seem to indicate more disorientation with respect to the present environment than active disorganization in behavior. Marked periods of "freezing of movement" (defined by us as cessation of movement in a posture requiring resistance to gravity, e.g., ceasing movement for several seconds with arms at shoulder height) and "stilling" (defined by us as cessation of movement in a relatively restful posture, e.g., falling prone and ceasing motion, or leaning back against the parent, unmoving) occurred in many infants who had previously been identified as unclassifiable. The infant usually had a dazed, somewhat disoriented expression during these episodes.

The infant of a clinically depressed mother stilled immediately following reunion. When mother entered the room in the first reunion episode he rose, took two steps toward her, and then fell prone in a depressed, huddled posture for many seconds. At mother's second entrance, he placed his hands over his mouth, bowed his head, and fell prone again, crying. Lifted and held on mother's lap, he again bowed his head and stilled completely for one minute.

Direct Indices of Apprehension Regarding the Parent

Main and Hesse (this vol.) have suggested that a state of fear or apprehension regarding the parent (originating in a parent whose behavior is *either* frightening or frightened) may be involved in the development of the disorganized/disoriented response pattern for many infants. As such, it may play a role in many of the behavior patterns listed earlier in table 1 (e.g., interrupted approach movements and avoiding the parent directly following a greeting). However, in some dyads—particularly those seen in maltreatment or high-risk samples—we have observed more direct indices of apprehension. For example, one maltreated infant approached her mother hesitantly, then moved quickly away with raised shoulders, her neck bent forward in a tense, hunched posture. Others approached the mother with head and chin tucked, leaving quickly.

At a theoretical level, signs of apprehension may seem less disorganized or disoriented than many of the other behavior patterns listed in table 1. Simply increasing one's distance from a feared individual is hardly an indication of behavioral disorganization. *Fear of the attachment figure in an attached infant*, however, usually *results* in disorganization of behavior, because the infant is not in a position to completely withdraw from the attachment figure and in stressful situations may need to approach her. Thus, the attached but fearful infant may greet the parent with a fearful smile or approach in a disorganized manner rather than simply withdrawing (see George & Main 1979).

Direct Indices of Disorganization or Disorientation

Table 1 describes only a few of many direct indices of confusion, disorganization, or disorientation. Turning and "greeting" the stranger rather than the parent was observed in several infants at the moment of the parent's entrance. Two maltreated infants pursued the parent, protesting departure,

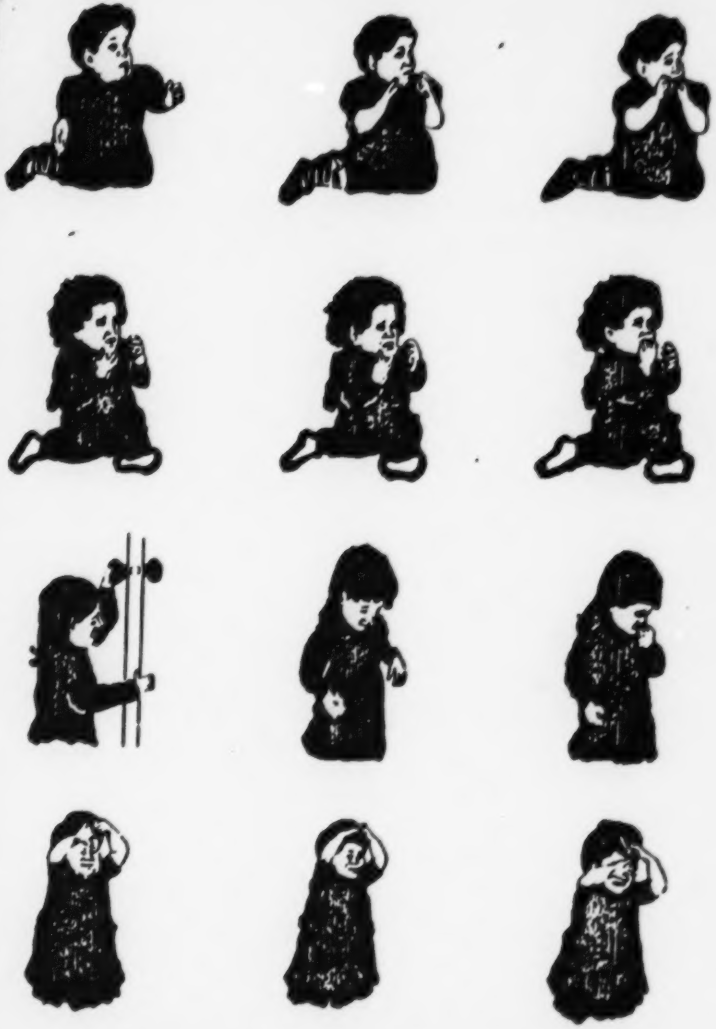

Figure 1. Responses of four infants, 12 - 18-month-olds, to parent's entrance to the room (drawings taken directly from film). All gestures occurred within eight seconds of entrance. For three of these four infants, the best-fitting traditional category was *B* ("secure").

then smiled immediately "at" the closed door. Some infants crept rapidly after the stranger, crying at her departure as though at the departure of the parent.

Directly upon sighting (or even hearing) the approach of the parent, some infants exhibited confusion. We observed one infant hunch her upper body and shoulders at hearing her mother's call, then break into extravagant laugh-like screeches with an excited forward movement. Her braying laughter became a cry and distress-face without a new intake of breath as she hunched further forward. Then, suddenly, her face lost all expression.

One of the most striking expressions of confusion was a hand-to-mouth gesture which occurred immediately upon reunion in several of the disorganized infants (see fig. 1). One child had been crying and calling during separation but immediately on reunion bowed his head, stepped backward away from the parent, and put hand to mouth in a gesture resembling indecision, shame, or apprehension. Two of the infants put both hands to mouth and cheeks immediately upon hearing the mother's call. The impression in one case was of confusion, and in the other confusion mixed with fear. Several of these direct indices of confusion, disorganization, and/or apprehension observed at the parent's entrance are shown in the drawings taken from videotape in figure 1.

DIRECTIONS FOR DETERMINING WHETHER AN INFANT SHOULD BE ASSIGNED TO DISORGANIZED/DISORIENTED ATTACHMENT STATUS

This is a list of steps to be taken in determining, first, whether a given infant's Strange-Situation response is or is not classifiable within the traditional system (*A*, *B*, *C*, U_{AM}) and, second, whether the infant is to be assigned to disorganized/disoriented attachment status. The directions given in this section are summarized in table 2 (page 148). The system should be applied only under the following conditions:

1. The individual working with the system must be thoroughly familiar with, and reliable in utilizing, the Ainsworth *A*, *B*, *C* infancy classification system (Ainsworth et al. 1978). The worker must be familiar enough with the *A*, *B*, *C* system to recognize an infant who fails to meet the traditional classification criteria. This will also assist the worker in, for example, recognizing expected versus unexpected temporal patterning in infant behavior.

2. The sample being studied should be one in which subjects are presumed neurologically normal. Obviously, an occasional subject will have unexpected neurological or motor difficulties, which may be recognized by the researcher only following interviews with the parent or, indeed, following direct observation.

3. The *D* system should be applied to the infant's behavior only when the

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parent is prese
such as inhibition of
is confronted by a stra
4. The *D* classi
12 and 18 months old. Child
in the Strange Situation is
no overtly disorganized behavior,
or other response patterns. The *D*
typically exhibited a relatively
trolling caregiving response
Cassidy 1988). Similarly, Crittenden has
maltreated children develop a compliant
tern (Crittenden 1987).
We have applied the *D* criteria shown
dren up to 18 months, but at 21 months we
since the beginnings of "controlling" and
now make an appearance in some children.
unaltered following 21 months seems doubt
5. The Strange Situation must be st
inherently confusing to the infant in the a
instructions to the parent. If the parent ope
walks to another part of the room before
will naturally appear disoriented at the first
seemingly "disorganized" approach by se
tion, stopping, and moving away. Similarl
and step over a barrier in the middle of h
one door but appear at a second; read thro
inclination but in accordance with laborat
movements by a loudspeaker in room ce
may disorganize or disorient an otherwise
6. Clear video recording, complete w
sion and small motor movements througho
If a stationary camera placed in one corn
record of the Strange Situation; if the film
back is to the camera upon reunion, it is
curate. In such cases, expressions of con
visible on the film, so that some *D* behav
inaccurately judged *D* on account of prol
was watching something closely, with a li
7. The observation and recording of
conjunction with repeated, slow-motion s
observer find and describe the behaviors.

Appendix IX
(from Main & Cassidy, 1987)

Introduction to the Avoidance Scoring System

This scoring system deals with the intensity, persistence, duration and promptness of the child's avoidance of physical or emotional interaction, proximity, or contact.

Avoidant behaviors may be defined as any behaviors which function to maintain or to increase the physical or affective and emotional distance between the child and parent, through a shift of attention away from the parent, or through preserving attention to other occupations, conversations, or objects.

The critical moments for avoidance are those for which acknowledgement of intimacy of relationship is most expected. Thus, the first moments of reunion after a substantial separation, as well as any moment at which the parent requests the child's attention are moments of special importance.

A highly avoidant child may initiate certain types of proximity-seeking or interaction when the parent's attention is focused elsewhere, or at moments when proximity and interaction are not expected. Acknowledgement of the relationship at the moment of reunion, and at moments when the parent seeks acknowledgement, is, however, avoided. At such moments, the child may be at special risk for displaying affection, distress, or anger and hence may seek to maintain a distance through avoidance.

What behaviors are considered avoidant? A partial list includes: moving away from the parent on reunion; keeping the back turned or actively turning the back to the parent on reunion; seeming pre-occupied with toys or persons other than the parent, while the body is kept slightly aligned away from the parent; ignoring the parent's overtures while looking otherwise pre-occupied; responding to overtures whenever necessary, but as minimally as possible; and attempting to distract the parent's attention to things other than the child herself.

As the reader will infer from this list, *the tone of avoidance is neutral*. Both affection and anger are absent. Contra-indications for avoidance include proximity-seeking or verbal initiations which are genuinely affectionate or relationship-acknowledging; eager responsiveness in conversation; full, open looks into the parent's face; *and* annoyance, anger, or punitiveness, however expressed.

Because avoidance is neutral rather than either affectionate or confrontational in style, a highly avoidant child needs to adopt different strategies depending upon the behavior of the parent. If parent as well as child fails to acknowledge reunion, the highly avoidant child can maintain distance from the parent through silence, failure to greet, and failure to initiate. But *if a parent presses hard or repeatedly*, a six-year-old child who wishes to maintain distance in order to avoid emotional interaction needs to give some minimal replies. The six-year-old, in contrast to the one-year-old, is likely aware that failure to respond when pressed risks *increasing* parental attention, and hence creating an emotionally tinged confrontation. In such a cirumstance, the child may not only reply, but may also initiate proximity or conversation which is neutral in topic or tone. A highly avoidant child, in contrast with a punitive or confrontational child, is willing to respond as seems necessary to maintain emotional distance, and may even greet the parent with the apparent purpose of getting past the social amenities. A highly avoidant child ignores the parent's initiations *only so long as it is possible to do this while appearing otherwise occupied.*

Because the function of avoidance is to avoid affectively tinged interchange, a highly avoidant child will appear merely busy while ignoring the parent, and in interaction will appear neutral or polite. Even in moving away from the parent soon following the reunion, the child will appear not really to be moving away from the parent but rather to be moving towards something else. Thus the child appears to need to fetch an object for further play in the sandbox, or merely to want to return immediately to play already established. Similarly, in turning away or remaining turned away, the child seems to be getting something or playing with something. Not to have such a rationale for moving away or staying away from the parent would be to risk confrontation. A highly avoidant child does not really want the parent to ask what she is doing or why.

Avoidance is scored on a 1 to 7 point scale, where 1 indicates no avoidance, and 7 indicates strong avoidance. Before moving to the actual directions for rating, you should read the following three sections of the rating manual. These are:

A. Indications of avoidance. This section lists behaviors considered both moderately and strongly avoidant. It also stresses the importance of context in judging avoidance at six years of age. In certain contexts, not speaking to the parent when spoken to is avoidant, while in others it is punitive or confrontational. In certain contexts, not-looking is avoidant, whereas in others it seems to signal feelings of hurt or anger, and as such is only minimally avoidant.

B. Forms of greetings, speech, and proximity-seeking CONSONANT with high avoidance. The highly avoidant child may occasionally greet the parent, approach the parent, or speak with the parent. In this section, types of greeting, speech and proximity-seeking which are consonant with the maintainance of emotional distance between parent and child are listed. Each of thse can appear in a child who shows strong avoidance, without reducing the rating for avoidance.

C. Forms of greeting, speech, and proximity-seeking INCONSONANT with high scores for avodance. Genuinely affectionate, openly angry, and any other relationship-acknowledging behavior is inconsonant with high avoidance. If it appears following moderate to strong avoidance, it represents a break-down of avoidance, and high scores can no longer be given. Similarly, high scores cannot be given if the child, while keeping her back turned much of the time, strongly expresses anger toward the parent.

Judges score an episode by first looking for indications of avoidance, and then seeing whether greeting, speech or proximity-seeking is of a type to reduce the score otherwise given for avoidance.

A. Indications of avoidance

The moment of reunion is a moment when re-establishment or affirmation of relationship is most expected or called for. Strong avoidance at this moment indicates that the child is unable or unwilling to acknowledge or affirm the relationship. A child can maintain or increase the distance between herself and the parent through several means: physical avoidance, visual avoidance, and avoidance of conversational response.

At 12 to 18 months of age, these three behaviors--moving away from the parent, averting the gaze from the parent, and not responding when addressed-- are all considered avoidant behaviors. Yet by six years, behavioral meaning has changed. At six, almost all physical movements away can still be considered avoidant. By six, however, failing to look and failing to speak can serve an emotionally communicative function rather than an avoidant one. By this age, the child has frequently learned the unwritten social rules. At times, not-looking is not avoidant so much as it is communicative of hurt or hostility (as is not-speaking). At other times, not-looking and not-speaking are still efforts to avoid communication.

Moving away from the parent on reunion, which is almost always considered avoidant, is discussed first here. The importance of context in visual avoidance and conversational avoidance is then discussed.

Physical avoidance

Physical avoidance includes moving away, orienting or remaining oriented away, and aligning the body away from the parent. What is it that the child is avoiding? The child seems to be avoiding not only proximity and contact, but also any orientation which would make communication--especially, affectively tinged communication--more likely. Physical closeness and body alignment are

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not only communicative in themselves, but they also make mutual attention and communication more likely. Ventral-ventral contact or even ventral-ventral orientation across a distance are especially likely to be avoided.

If a child shows *any* of the following behaviors at the moment of reunion, the child will receive a very high rating for avoidance, *unless* there is strongly affectionate or angry initiation or responsiveness later in the episode.

a. Moving away from the parent almost immediately upon reunion, i.e., just following an initial greeting. (Be careful here. Most avoidant children will appear to be getting a toy, and all will have some rationale. Moving away is meaningful in itself. Even if a child merely immediately moves away to get something to bring back to the parent, the move away is slightly avoidant.) A move away in which the child remains at a distance is highly avoidant.

b. Turning the back to the parent upon reunion, and staying with the back to the parent for more than 5 seconds.

c. Keeping the back oriented to the parent on reunion, i.e., not turning about to look at the parent, or looking only very briefly about, as though out of curiousity. This is given a high score if the child remains with back turned more than 5 seconds. (Note. Remaining oriented away from the parent is not a movement, but nonetheless it is highly avoidant. It indicates the child is busy; it indicates that this is not a special moment; and it leaves the child in a position from which little further communication can be expected).

d. Moving forward to greet the parent, then dashing away from the parent with the back to the parent, and usually forward into the room. Here the child seems to have attempted to greet the parent, then suddenly to have had to turn away and move away with the back to the parent. Again, because the avoidant child always looks neutral and seems to have a rationale, the child in this circumstance usually looks as though she is merely leading the parent into the room, going back to play, or going to interact with the other parent. Nonetheless, such a strong move away indicates a strong difficulty acknowledging the relationship, and hence is avoidant.

All the above behaviors yield high scores for avoidance only when they occur immediately upon reunion. A minute or so following a full greeting, moving away to play or to speak with the other parent may not be at all avoidant.

Other physical movements or orientations which should yeild *some* score for avoidance are:

a. Keeping the body or head angled away from the parent, keeping the shoulder interposed between self and parent, etc.

b. Breaking contact with the parent, no matter who initiated the contact.

c. Showing an aversion to ventral orientation or contact with the parent, even when in bodily contact with the parent.

d. Attempting, immediately upon reunion, to orient the parent's attention away from the child—e.g., "Look at that toy over there". This is an avoidant behavior, because it attempts to re-direct the parent's attention or orientation elsewhere, hence to avoid mutuality.

Visual avoidance—Averting the Gaze

At six, not-looking is still considered avoidant behavior if: the child distinctly aligns the head or body away from the parent and toward some other object of attention (toys, other parent, mirrors, etc.). Thus, if the child is not-looking because of being busily bent over the sandbox, talking with the examiner, or if the child is aligning the head so that the child could not see the parent without a major change in posture, the not-looking is avoidant. This is because with this type of visual avoidance, the child seems to try to indicate

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that he is too busy to interact just now, not a suitable candidate for attention, etc.

At six, not-looking is especially likely to be a meta-signal for hurt or anger, and hence only minimally avoidant, if:

a. The child has a fairly open physical orientation to the parent.

b. The child is interacting, initiating, or being at least moderately responsive, whether pleasantly or unpleasantly.

If a child looks down or seems muted while interacting either pleasantly or unpleasantly with the parent, the child seems to be adding a meta-communication to the present communication such as, "...and I'm a bit hurt or puzzled, so you might want to ask me about it", or, "...I'm not only feeling nasty enough to speak to you the way I'm speaking to you, but you can't make me look at you either".

So, a muted not-looking *while interacting* (or in the context of being interactive frequently during the episode) is not really avoidant. As a rule of thumb, add only 1 point to what would otherwise be the child's score for avoidance. pattern.

Conversational avoidance: Not-speaking, and "minimizing" responses

To begin with, at six, there are general qualities of response or initiation in speech which are indicative of avoidance. These include:

a. Flat tones in speech.

b. Dismissing tones in greeting.

c. Minimal responses to questions, and statements from the parent. These minimal responses can be safely used by a highly avoidant child because they do not increase the likelihood of further conversation, yet they are satisfactory

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enough that they do not attract increased attention from the parent. As an example, the parent may ask, "So, you've been playing all this time with Carol?", and the child may answer "Yeah", or the parent may ask, "So, what have you been playing with?", and the child may answer, "The truck".

The general sense gained from these qualities of speech is that the child is busy or pre-occupied, but willing to get through the social amenities while not encouraging further conversation.

When the child is directly addressed by the parent and does not reply, not-speaking can be either avoidant or communicative. At six, not-speaking when addressed is still avoidant rather than communicative if:

a. It is accompanied by efforts to look busy or as though it was not possible to hear the parent.

b. It occurs at a point where the parent could be, or was, interacting with someone else anyway, and only addressed the child casually.

c. It occurs when the child has her back to the parent, or is markedly oriented away from the parent, which would already indicate that attention is elsewhere.

In general, *not-speaking is avoidant if it could go unnoticed*, or if the child may think it could go unnoticed, or if the parent could reasonably think the child did not hear, did not notice, or was merely pre-occupied. Thus, silence or ignoring in these contexts is discouraging of further efforts on the part of the parent, but is not confrontational. The child's failure to respond communicates, "I really am busy/am thinking of something else/didn't notice what you said/didn't hear you".

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At six, *not-speaking when addressed is punitive and confrontational rather than avoidant if it seems to function to humiliate, hurt, or embarrass the parent*. This is the case when:

a. The parent is in a position to easily see the child's face, the child refuses to respond or speak, and the child does not bother to orient away from the parent to "cover" for this failure of response.

b. The parent is speaking in a manner which betrays a "need" for the child to respond vocally. For example, the parent addresses the child repeatedly, without answer from the child. The embarrassing or even humiliating apparent intent of this behavior was particularly striking in our Berkeley study, where the child behaved in this way "in front of" the examiner.

c. The parent is greeting the child--a moment which the child knows by age six to be especially sensitive.

As a rule of thumb, add only about 1 to 1.5 points to what would otherwise be the child's score for avoidance.

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B. Forms of Greeting, Speech, and Proximity-Seeking CONSONANT with Strong Avoidance

Children receiving the highest scores for avoidance may nonetheless greet the parent (either in response or in initiation), respond when addressed, initiate certain types of conversation, or approach the parent for certain purposes. In many or most cases, these initiations or responses seem to maintain the interactive distance between child and parent. In some cases, it seems clear that they are, in fact, *necessary* if distance is to be maintained.

Forms of Greeting Consonant with Strong Avoidance

Greeting, smiling, and showing the parent something may be seen in avoidant children who seem to need to get past the social amenities in order to maintain social distance and to avoid further, possibly emotional, interchange. Watch carefully for signs that an apparent greeting is actually avoidant of continuing or opening communication. Watch here for a flat or dismissing tone of voice, or a limited or "false" smile. At the moment of reunion, the avoidant child may show the parent a toy in a way which distracts the parent's attention from the child. This is contrasted with showing off of something the child has done or accomplished, a behavior which would lead to further personal contact.

Forms of Speech Consonant with Strong Avoidance

Conversational initiations or responses which:

a. Are simply neutral or businesslike, and do not suggest a need for further affective interchange between child and parent (essentially, which are "rhetorical"). As an example, the child responds with "Yeah, I drew the family", "Nope", "The truck", "Uh-huh", "I need a pencil".

b. Are help-seeking or help-offering when the tone is polite or neutral, as to a neighbor or teacher. As an example, the child says, "Fix my buttons", "I can

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find it", "You can get at it from here".

c. Occur in response to the parent's repeated pressing of the child for information. The avoidant child who is repeatedly or strongly pressed by the parent has to make some acknowledgment, and may do so by giving minimal repeated "yes" or "no" answers, or giggling self-consciously without looking at the parent (seen twice in girls attempting to "avoid" a particularly pressing father), or even by trying to make some sort of initiation. This repeated pressing necessitates some response in order to maintain distance.

d. Are odd in content, senseless, pointless, or strange. In addition, conversation with content which is, in a neutral way, threatening or aggressive. Such speech neither encourages interaction nor brooks emotional response from the parent. Examples: "Eeech, eech, eech!", or "Tigers, tigers, tigers gonna throw you up!", or "You're gonna be sick, so sick" (said in an odd, affectless sing-song, directed to no one). This speech is not directly aggressive or confrontational, hence it does not reduce a score otherwise given for avoidance.

Forms of Proximity-Seeking Consonant with Strong Avoidance

a. Proximity-seeking or contact-seeking which is business-like in purpose (help-seeking, e.g., fixing the child's buttons, or help-offering, e.g., showing the parent politely the way to the bathroom); odd in purpose; or aggressive in purpose.

b. Proximity-seeking immediately upon reunion which is followed immediately by dashing away from the parent and forward into the room, towards a toy or other person, etc. The initial movement toward the parent may be one of intended greeting—but if this is followed immediately by a move away, a strong score for avoidance may well be given.

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C. Forms of Greeting, Speech and Proximity-Seeking INCONSONANT with High Scores for Avoidance

In general, any greeting, pattern of speech or proximity-seeking which is intimate, emotional or confrontational is inconsonant with high scores for avoidance.

Forms of Greeting Inconsonant with Strong Avoidance

"Secure" or genuinely positive greetings which are an immediate, full acknowledgement of the parent's return, and hence subtly of the importance of the parent's absence. Examples include:

a. Full, genuine greeting and look of pleasure or delight.

b. Deliberate craning about to look fully into the parent's face.

c. Immediate remark acknowledging the separation, such as, "Mom, guess what we did while you were gone?" (Oppose this to an at least potentially avoidant greeting of, "Look at the toy horse", which does not recognize absence, reunion, or relationship).

d. "Insecure" or negative responses to reunion which are rejecting of the parent, humiliating to the parent, or embarrassing to the parent, and hence confrontational. Here too the relationship is immediately recognized and called upon, even though the expression may be punitive silence or overt rejection.

Forms of Speech Inconsonant with Strong Avoidance

Conversational *initiations* such as the following:

a. Inviting parent to play with or join child.

b. Showing interest in the parent's own activities.

c. Making a supportive remark to or about the parent.

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d. Making a personal remark about her own state or that of the parent, positive or negative ("I'm really tired", and, "You are a big bore" are both personal and non-avoidant).

e. Initiating a new topic of conversation which can be readily expanded upon by the parent, such as, "I made a castle just like the one we have at home, remember?"

f. Making an openly angry, rejecting or humiliating remark to the parent.

Conversational *responsiveness* with the following characteristics:

a. Quick responses to the parent's speech, as though eager, or at least very familiar and ready. This may be, again, either positive or negative.

b. Eager interruptions of the parent's speech for the purpose of communication (interrupt to answer, to ask questions, to tell of own activities).

c. Fuller responses to parent's speech or questions than is necessary (expansions). In response to "Did you make that?", the child says not merely "Yes", but, "Yes, I made that one and this one too. I'm an architect!".

d. Expanding on conversation or questions. "Yes, and I made this and this too. Actually, you oughta see the blue one. I made it first".

Forms of Proximity-Seeking Inconsonant with Strong Avoidance

Any form of affectionate contact, whether direct or having a familiar casualness, is inconsonant with high scores for avoidance. (But see forms of proximity-seeking which are not inconsonant with strong avoidance, such as those which are subtly aggressive, theatening, or uncomfortable, or proximity-seeking which is followed immediately by a dash ahead of or away from the parent).

Avoidance Rating System

The original system for scoring avoidance was devised by Ainsworth for use with 12-month-old infants in a situation in which the behavior of the mother was substantially controlled. Her scoring system described over 20 exact behavior patterns, with some modifications for the mother's pressing or not pressing the infant for interaction.

Because Ainsworth could identify most of the possible "avoidant" patterns which would be seen in the repertoire of the one-year-old, her system was justifiably called a scoring rather than a rating system. Thus, each major pattern of response was listed, and judges identified the pattern and gave the score for avoidance only afterward.

The present system is devised for use with six-year-old children in a situation in which the behavior of the parent is completely uncontrolled. Moreover, the situation is complex socially, in that the adult examiner does not leave the room on the parent's return, and (in the Berkeley laboratory) the second parent returns to the child, the examiner, and the first parent. In addition, the repertoire of the six-year-old is almost as complex socially as the repertoire of the adult, and the six-year-old can use language to avoid, or to re-direct the parent's attention.

This given, it is not possible to devise a scoring system which will give the judge the full repertoire of behavior patterns. The children in each sample must be rated relative to one another, and we suggest training on an initial sample of 15 reunions which represent the full range of avoidance (from none, to the highest score of 7) found in the sample to be considered. The judge should be thoroughly familiar with all parts of this avoidance scoring manual, and should review it frequently.

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In scoring a reunion, the procedure is as follows:

a. Review the section of this manual entitled "Indications of Avoidance", and note any which are present on the tape.

b. No child is avoidant throughout an entire reunion episode unless the parent is completely cooperative in maintaining the avoidance, and does not address the child nor approach her. Therefore, examine all greeting, speech, and proximity-seeking carefully, using the relevant parts of this manual to determine whether it is of a form consonant or inconsonant with high scores for avoidance.

c. This rating system is a final guideline, but it is necessarily limited. Children may show combinations of behavior not listed here. Your overall sense of the degree of avoidance relative to other children in the same sample is also a guideline to the rating given for avoidance.

SCALE FOR RATING AVOIDANCE

Avoidance is scored on a 7-point scale for easy comparison with the Ainsworth system. A score of one is given if the child shows no avoidance, a score of 7 if the child shows very strong avoidance.

A score of "1" can be given under any of the following circumstances:

a. The child greets the parent with delight, and easy interchanges follow. Occasionally the child looks away or is occupied with other things, but this happens only after the relationship is clearly re-established.

b. The child greets the parent or responds to the parent, but without ardor or special delight. Soon after reunion, the child either looks into the parent's face lingeringly or fully, or verbally re-affirms the special nature of the relationship. These signs of readiness for communication may follow a casual greeting, but in their fullness they are meaningful even though they are not accompanied by smiles.

c. The child greets the parent with hostility or rejection, and is controlling or cruel during the episode. There is no physical avoidance, however, and the child seems to look at the parent readily. The response to the parent is immediate and not casual.

d. Note that following a full greeting, a return to play, or a turn to conversing with the other parent or with the examiner is not considered to be avoidance of the parent.

Low scores (1.5 to 3.5) can be given if the child shows brief but limited, or persistent but faint avoidance

a. The child is largely responsive and interactive, but fails to look at the parent while responding and interacting as much as would be expected (low score).

b. Brief avoidance of the parent, as in not-looking or a delay in reply, followed by responsiveness and initiations--but, the child does not look at the parent as much as would be expected.

c. Hostile responses to the parent, followed by continuing hostility or punitiveness while looking down or refusing to meet the gaze of the parent.

d. The child gives a genuinely positive greeting, but this is followed by some active avoidance or avoidantly casual interaction, or by an "avoidant" response to contact with the parent.

e. Sharp immediate avoidance which is followed by real responsiveness or by initiations of contact of a genuinely affectionate (or even caregiving) nature. The score here depends on the degree to which the child warms up to, or even

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takes the initiative with the parent through behaviors inconsonant with high scores for avoidance.

f. Brief period of ignoring the parent followed by regaining of responsiveness or by making initiations to the parent.

g. The child is slow to look at the parent or to respond to her overtures--but then she does respond. However, while she acknowledges and responds to the parent's overtures, she is muted and is not initiating (higher end).

h. The child greets the parent, then shows some slight reserve. She is then responsive either in interacting with the parent or in exchanging looks, smiles, and conversation in the course of play. She does not, however, take the initiative in seeking interaction and contact.

i. The child's initial avoidance is very slight, but there is a mutedness accompanying responsiveness throughout the episode. The eyes are downcast, or the child is a little slow to respond (as though she is faintly hurt or puzzled), but generally she seems at ease with the parent (low wscore).

Moderate scores can be given if the child shows brief but strong avoidance; or a persistent, low-keyed voidavoidance (seeming too casual) 3.5-5

a. Strong avoidance followed by some real responsiveness (friendly or hostile) which is nonetheless slightly limited.

b. The child greets her parent (positively or negatively) and may start to approach her, but then shows some avoidance. The child continues with her play, or conversation, perhaps with occasional looks, smiles, or interchanges with the parent. What is avoidant here is the failure to "recognize" the separation in the excessive casualness of the interchange upon reunion.

c. The child fails to greet the parent and ignores the parent most of the time, keeping busy with other things. However, there are flashes of some directness, whether of rejection or warmth, and these flashes show an underlying relatedness. The child does not really "warm up" to the parent over the episode, however. There is no flow of responsiveness and no real initiation.

d. The child ignores the parent at first, then responds, but without much elaboration. The child's behavior may be "difficult", or even faintly punitive, but perhaps because of this there seems to be a parent-child connection. A striking element may again be casualness, as though nothing had happened.

High scores can be given whenever the child seems extremely neutral, or organized, or rigid with respect to the parent 5-7

High scores are given when it seems unlikely that the child could easily break through avoidance to expressions of anger, affection, or hurt and distress. They can be given even when the child gives a flat initiating greeting, and even when the child seeks proximity for certain purposes (as, to politely show the parent the way to the bathroom, as though the parent were a neighbor or teacher).

Scores above 5.5 cannot be given if the child shows clear annoyance, clear pleasure, or hurt during the episode. Nor can they be given if there is affectionate contact-seeking, or initiations of personal or inviting conversation.

a. The child keeps her back to the parent for longer than 5 seconds following the parent's entrance. There is a definite rigidity or stiffness. The child may then break this rigid orientation with an initiation of a neutral type; or may converse with her back to the parent; or may remain oriented away even when the parent approaches or touches, then make a "necessary" response or initiation of a type consonant with strong avoidance (highest score for this last pattern).

b. There is an approach followed immediately by withdrawal. This is usually

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seen as dashing into the room ahead of the parent, back to a toy or to the other parent, etc. After this, interaction has a neutral quality.

c. The reunion looks neutral, innocuous, affectless, unimportant. The child may "greet" the parent, observing the amenities. After that, the parent does not press for interaction, and the child remains otherwise occupied, without speaking to the parent for all or most of the episode.

d. The child attempts to ignore or avoid the parent on reunion, but the parent presses continually for interaction. The child gives minimal acknowledgements, in the forms of words or perhaps of little giggles, but there is no initiation on the part of the child and no responsiveness other than what the parent has made necessary.

Appendix X

Manuscripts Using Attachment System for 2 1/2 - to 4 1/2-year olds

Papers Presented

Beckwith, L., & Rodning, C. (April, 1991). Stability and correlates of attachment classifications from 13 to 36 months in a sample of preterm infants. Paper presented at the meetings of the Society for Research in Child Development, Seattle.

Cassidy, J., Berlin, L., & Belsky, J. (April, 1991). Attachment organization at age 3: Antecedent and concurrent correlates. Paper presented at the meetings of the Society for Research in Child Development, Seattle.

Cicchetti, D., & Barnett, D. (April, 1991). Attachment during the preschool years: Examination of a new measure. Paper presented at the meetings of the Society for Research in Child Development, Seattle.

DeKlyen, M. (April, 1991). Disruptive behavior disorder and the internal representations of attachment of preschool boys and their mothers. Paper presented at the Biennial Meeting of the Society for Research in Child Development, Seattle.

DeKlyen, M., Endriga, M., Speltz, M., & Greenberg, M. (April, 1992). Representation of caregiving relationships in mothers of behavior problem and normal preschool boys. Paper presented at ICIS, Miami.

Endriga, M. C. (April, 1991). Assessing internal working models of attachment in preschool-age boys with disruptive behavior disorder. Paper presented at the Biennial Meeting of the Society for Research in Child Development, Seattle.

Greenberg, M., & Slough, N. (April, 1991). Attachment security and its correlates in preschool children: Validation of reunion assessment. Paper presented at the meetings of the Society for Research in Child Development, Seattle.

Speltz, M. L., DeKlyen, M., & Endriga, M. (April, 1991). Controlling patterns of reunion behavior in preschool children with disruptive behavior. Paper presented at the Biennial Meeting of the Society for Research on Child Development, Seattle.

Stevenson-Hinde, J., & Shouldice, A. (April, 1991). Attachment on reunion at 2.5 and 4.5 years: Stability, other indices, mother/child interactions, and peer/peer interactions. Paper presented at the meetings of the Society for Research in Child Development, Seattle.

Publications

Achermann, J., Dinneen, E., & Stevenson-Hinde, J. (1991). Cleaning up at 2.5 years. British Journal of Developmental Psychology, 9, 365-376.

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Bretherton, I., Ridgeway, D., & Cassidy, J. (1990). The role of internal working models in the attachment relationship: Theoretical, empirical, and developmental considerations. In M. Greenberg, D. Cicchetti, and E. M. Cummings (Eds.), Attachment in the Preschool Years: Theory, Research, and Intervention (pp. 273-320). Chicago: University of Chicago Press.

Cicchetti, D., & Barnett, D. (1992). Attachment organization in maltreated preschoolers. Developmental Psychopathology, 3, 397-411.

DeMulder, E. K., & Radke-Yarrow, M. (1991). Attachment with affectively ill and well mothers: Concurrent behavioral correlates. Development Psychopathology, 3, 227-242.

Greenberg, M. T., Speltz, M. L., DeKlyen, M., & Endriga, M. (1992). Attachment security in preschoolers with and without externalizing behavior problems: A replication. Developmental Psychopathology, 3, 413-430.

Pipp, S., Easterbrooks, A., & Harmon, R. (1992). The relation between attachment and knowledge of self and mother in one to three-year old infants. Child Development.

Shouldice, A., & Stevenson-Hinde, J. (1991). Coping with security distress: the separation anxiety test and attachment classification at 4.5 years. Journal of Child Psychology and Psychiatry, 33, 331-348.

Speltz, M., Greenberg, M. T., & DeKlyen, M. (1990). Attachment in preschoolers with disruptive behavior: A comparison of clinic-referred and non-problem children. Development and Psychopathology, 2, 31-46.

Stevenson-Hinde, J., & Shouldice, A. (1990). Fear and attachment in 2.5-year-olds. British Journal of Developmental Psychology, 8, 319-333.

Turner, P. (1991). Relations between attachment, gender and behavior with peers in preschool. Child Development, 62, 1475-1488.

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